PUBLIC HEALTH NURSING

27 February, 1935 Number 2

Public Health Nurse

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D., Head of the Department of Communicable Diseases
f Southern California; and EDITH B. PUSEY, R.N.,
ssion, Los Angeles General Hospital.

Philadelphia and London

PUBLIC HEALTH NURSING

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EDITORIALS

SLUMS—A MENACE TO PUBLIC HEALTH

The expansion of the Federal slum clearance and rehousing program as a major feature of public works and social security plans now before Congress contrasts sharply with a century of indifference and inaction in the field of low-rent housing. The community work of public health nursing services among occupants of congested or unhealthy areas bears eloquent testimony to the inter-relationship of slums and health.

The social importance of housing is now generally recognized in our country. Dr. Haven Emerson has said:

> Health of body and mind, soundness of social life, freedom to rest and play are all dependent so much upon the quality of housing shelter for the wage earner and his family that provision of this type of essential utility cannot be left to the accident of competitive exploitation of land and buildings. It calls for active participation by government in the control of conditions of financing the purchase of land and the building of homes and in the uses to which dwellings for one or many families are put by landlords and tenants. Certain health hazards can be removed only by destruction of the types of building incompatible with safe and sanitary occupancy, of which there are many thousands in all our large cities and in some of our smaller ones, and their replacement by such home buildings as we now know can be provided within city limits and within the means of families of small means, guaranteeing the essentials of good housing.

The menace of slum areas to public health was further emphasized in a recent bulletin of the U. S. Public Health Service. Rollo H. Britten, senior statistician of the service, stated: "Communicable diseases endemic to slum areas are likely to be carried into other parts of the population." Housing surveys and health reports blanketing the country reveal that outside of the desperate human need as demonstrated in the study made by the U. S. Public Health Service of adverse health factors present in all slums, for economic reasons as well, municipalities cannot go on paying heavily for the increasing costs of maintaining obsolete areas.

In determining the effect of substandard housing conditions on public health, the U. S. Public Health Service found that while overcrowding plays the major rôle in spreading childhood diseases, fresh air and sun starvation prevent wholesome development of the individual. Sunless, unventilated tenements offer the body of a child none of the elements needed for its growth. Rickets, continued nasal infections and the childhood diseases rage unchecked where such conditions obtain. Added to these physical factors is another penalty on the life of the slum child: the psychological effect, unmeasured and immeasurable.

The definite improvement found among rehoused segments of the urban population in England is cited in the public health bulletin to show the influence of substandard housing on community health. In Liverpool, prior to rehousing, the death rate stood at 37 per thousand for one specific group of slum dwellers; new homes of higher standards cut this to 26.6. In the same area tuberculosis death rates were halved by rehousing the population, and the infant mortality rate fell by 97 per thousand.

Terming insanitary tenements "health hazards," Mr. Britten declared: "These facts, together with European data showing a reduction in mortality rates associated with rehousing projects, indicate that poor housing is a public health as well as a sociological problem and therefore one of immediate concern to health authorities."

The problem of providing adequate dwellings for the lower economic third of the population has grown in intensity, because the old law of supply and demand has failed to operate in relation to the availability of decent homes at sufficiently low rent. Hence, some ten million families in the United States today occupy ramshackle, sunless dwellings, lacking the barest of living facilities.

Surveys such as the Real Property Inventory, conducted by the Bureau of Foreign and Domestic Commerce, reveal rural, urban and suburban areas throughout the country where shacks or tenements unfit for human habitation continue to serve as homes for generation after generation of American citizens and their offspring. Acres of shoddy, rundown houses in squalid towns and villages are spread across the country. There is no industrial or commercial town of 10,000 in the United States that does not possess rundown districts whose effects on the health and safety of their inhabitants are not so injurious as the substandard areas of Chicago, New York, or San Francisco. It will be readily seen that the application of the low cost housing program to smaller rural and urban communities in most cases is as socially imperative as in metropolitan centers where the housing problem, due to the heavy pressure of population and overtaxed facilities, assumes an aggravated form.

People have railed against the slums for many years. Many weapons of attack have been tried and thrown aside as useless, insofar as they directly serve the housing needs of the great mass of wage earners. Remedial legislation and the adoption and administration of tenement house laws, philanthropic and model dwellings, limited dividend projects—each has had its time and still has its place. But no one of these methods has reached to the heart of the housing problem—the problem of workers to secure adequate homes at rents within their means.

Public housing is a new experiment for America, but European countries have long since depended upon government loans and subsidies, together with municipal programs of slum clearance and low rent home production, for the abolition of unhealthy and insanitary areas.

Through the Housing Division of the Federal Emergency Administration of Public Works, policies have been formulated and funds appropriated in the past year for programs of slum clearance and low-cost housing by public bodies. The cities of eight states (New York, Michigan, Illinois, West Virginia, Ohio, Kentucky, Maryland and South Carolina) now have the necessary power to create municipal housing authorities such as are now operating in New York, Schenectady, Cleveland, Cincinnati, Dayton, Detroit, Toledo, Columbus, Youngstown and Columbia, S. C. In 33 cities work is being pushed to develop the 39 projects which have already been approved. Colonel Horatio B. Hackett, Director of the Housing Division, PWA, reports that in addition to the $150,000,000 already appropriated, new projects totaling $200.000,000 have been submitted for approval.

The new Federal policy of furnishing low-rent housing, both as a recovery

measure and a necessary social service, offers a challenge to every public health nursing service and to the staffs of health departments in the towns and cities of America to help in organizing their communities to participate in this income-producing Federal program. As champions of public health, the effectiveness of their group action toward the initiation and development of public housing programs cannot be overestimated.

In over three dozen states enabling bills must be prepared, introduced and passed by state legislatures. By the end of the 1935 legislative sessions, no city should longer be denied power to clear its slums and to rehouse those families at present ill housed. The National Public Housing Conference for three years has fostered low-rent housing for workers by public authority, on publicly owned lands, and with the aid of public funds. Only the passage of the necessary State legislation and the formation of municipal housing bodies in all cities will assure the continuation and amplification of such a public housing program. The present opportunities for progress in this new field of public service offer to every health worker a real challenge to active participation in the public housing movement.

HELEN ALFRED,
Secretary, National Public Housing Conference, New York, N. Y.

A CURRICULUM STUDY—YOUR HELP IS NEEDED

The Central Curriculum Committee has agreed on the desirability of a study that will reveal typical nursing situations and problems that arise in the hospital, out-patient department, and the home, and the qualities displayed by the successful and the unsuccessful nurse when confronted with these situations. The Committee believes that such a study will disclose valuable material for courses which are to be constructed and show the type of behavior we may wish to develop in producing a capable and successful nurse. This particular project will be carried on through the Department of Studies.

In carrying out the proposed study, the first step is to assemble a fairly representative number of typical situations that are apt to occur in:

(1) Nursing the different kinds of diseases in the home and the hospital
(2) Carrying out preventive and health measures in nursing.

Two word pictures, if possible, should accompany each situation. One should describe the *successful nurse* as she functions in the particular situation and the other the *unsuccessful nurse* under the same conditions. In describing the traits exhibited by the nurse, as for example, "Consideration of the patient's family," it would be helpful if you would give one or two examples of the type of thing the nurse did or the way in which she behaved which showed such consideration. If it is easier for you to make a composite picture of two or more good or poor nurses, this would be quite satisfactory. We suggest that the descriptions be limited to about one sheet of paper. If you need a form to guide you we can supply you with one or several.

Obviously the raw materials for this study must come from experts who are directly engaged in the different types of nursing. We are, therefore, asking nurses to list typical situations in the various fields (that is, medical, surgical, public health nursing, etc.) and to describe the way in which the nurse functioned in them. Will you as a public health nurse help us in the study by sending in at least one situation with a description of the successful nurse and the unsuccessful nurse functioning in the situation? And may we have your material by the middle of February? Please send to:

Department of Studies,
National League of Nursing Education,
50 West 50th Street,
New York, N. Y.

Public Health and Immigration

By C. H. LAVINDER, M.D.

Chief Medical Officer, U. S. Public Health Service, Ellis Island, N. Y.

MUCH confusion exists concerning the public health aspects of immigration. The restrictive immigration laws are not designed as public health measures and while the public health significance of their enforcement may be important, yet it is incidental.

The purpose of these laws is to exclude undesirable aliens, and included among the undesirable qualities which an alien may possess are certain mental and physical conditions.

These laws are administered by the Labor Department. The Public Health Service, under the law, acts only in an advisory capacity by informing representatives of the Labor Department of the existence of mental and physical conditions which may make the alien undesirable.

AT ELLIS ISLAND

Ellis Island is the largest of the immigration stations and its work is typical of the work done elsewhere, except that it possesses a larger plant and better facilities. What is said here concerns almost exclusively the work done at Ellis Island.

In making medical examinations the work is so arranged that a primary medical examination of immigrants is made on board ship; and, so far as medical examinations are concerned, only those aliens go to Ellis Island who are sent there by the medical boarding officers. On arrival they are subjected to a more intensive examination. If this is not satisfactory they are sent to the hospital for a complete examination.

The work is so arranged as to separate as rapidly as possible those who can be passed and to retain for a fuller examination those who are suspected to have physical or mental conditions requiring certification.

Medical officers are stationed at certain points in Europe and on the borders of the United States, who make medical examinations of prospective immigrants, and these examinations are coördinated with the examinations made on arrival.

EXCLUDABLE ALIENS

So far as the medical examinations are concerned, there are two classes of conditions for which aliens are certified to the immigration authorities. These conditions are known as Class A and Class B.

Class A includes roughly all mental defects and abnormalities, persons with chronic alcoholism, persons afflicted with tuberculosis in any form, and persons who may be suffering from what the law calls "loathsome or dangerous contagious diseases." Aliens suffering from these conditions are mandatorily excludable.

The other group known as Class B includes a wide variety of conditions. Certification is made on one basis only, and that is that the condition affects ability to earn a living. The medical evidence in these cases is considered along with other evidence in the general examination of the alien, and judgment is by no means confined to the medical evidence.

CHANGE IN CHARACTER OF IMMIGRATION

The change in the volume and character of immigration in the past few years has necessarily resulted in modification of methods. This change is very significant. There was a time not long ago when Ellis Island handled something like 5,000 aliens daily over a long period of time. The last annual report of the Secretary of Labor for the fiscal year ending June 30, 1933, states that during the year there were admitted only 23,068 aliens for permanent residence, or in other words real immi-

grants. This by no means represents the total number examined because the law requires examination of non-immigrants as well as immigrants. For example, there are large numbers of visitors, persons in transit, aliens returning to an acquired residence in the United States, crews of foreign vessels and others. This swells the number of persons to be examined. For example, during the past year the Medical Service at Ellis Island examined a total of more than 800,000 people but these were not immigrants in the real sense of that word.

This change in immigration has, of course, resulted in a tremendous reduction in the number of persons admitted to hospital with a resultant large number of empty beds. The Government has seen fit to make use of these empty beds for other governmental beneficiaries and the hospital is therefore a very active place, carrying, as a rule, from 450 to 500 patients, only a part of which are immigrants or aliens.

At the present time there are a large number of aliens undergoing deportation in one form or another. The Secretary of Labor's report quoted above stated that alien recorded departures for the year mentioned, both emigrants and non-emigrants, were 243,802, the first class numbering 80,081 and the second 163,721. In other words, the outward movement now exceeds the inward movement.

OTHER INTERESTED AGENCIES

It is to be understood in speaking of the public health aspects of immigration that the Medical Service makes only a very brief contact with most of the aliens submitted to examination. It is only a small part of the whole who ever enter the hospital, and even many of these remain but a brief while, a day or so at most. The effect of excluding aliens who are undesirable by reason of physical or mental conditions is obvious. Perhaps the only other feature of this work which has much public health significance lies in social service and welfare work done among those persons who are detained at Ellis Island, either in the hospital or in the detention rooms. There are sometimes large numbers of aliens detained in the detention rooms for non-medical causes, and these are only seen by the medical staff in a daily sick call.

The hospital has an organized social service, devoted almost exclusively to patients other than alien patients. The social service and welfare work done among aliens, whether patients in the hospital or persons detained elsewhere, devolves upon a group of social and welfare agencies who have long carried on their activities at Ellis Island. The hospital social service represents little more than a liaison between aliens in the hospital and these social and welfare agencies.

To understand the situation at Ellis Island it must always be clearly appreciated that Ellis Island is primarily an immigration station, maintained for the administration of restrictive immigration law. It is in charge of a Commissioner who represents the Department of Labor. The Public Health Service performs the medical functions. In addition to this, there exists on the Island the group of non-official social and welfare agencies already mentioned. This group has existed on Ellis Island for many years and has done much to ameliorate the hardships which fall to the lot of many aliens.

The General Committee of Immigrant Aid at Ellis Island and the Port of New York, is an advisory agency for the promotion of coöperation and efficiency in Immigrant Aid work, and is made up of constituent Societies who contribute financially to the work. Their interests are varied—some stress occupational therapy; others are interested in an educational and recreational program; while the full-time agencies emphasize case-work and at the same time maintain their interest in the educational, recreational, and religious activities. The agencies active at Ellis Island are:

American Tract Society
Congregational Home Missionary Society
*Daughters of the American Revolution
*Hebrew Sheltering and Immigrant Aid Society
*Italian Welfare League
*Inner Mission Board of the United Lutheran Church
*New York Protestant Episcopal City Mission Society
*National Catholic Welfare Conference
National Council of Jewish Women
New York Bible Society
Women's Christian Temperance Union
*National Institute of Immigrant Welfare.

Many of the organizations are international and national in scope, and follow up the alien when he leaves the Island, putting him in touch with Social Service Agencies here and abroad.

It must also be kept in mind that the restrictive immigration laws were enacted for the benefit of the people of the United States and for their protection. The application of any general law necessarily results in hardships to a certain number of persons. Laws are more or less inelastic, otherwise they could not be enforced. It is unfortunate that some people must suffer but this does not mean that the law in itself is not a beneficent law. All agencies at Ellis Island, both official and non-official, seek to execute these laws to the best of their ability and seek in all ways to mitigate hardships which necessarily must at times occur.

This group of non-official, social, and welfare agencies stands in a peculiar position. They are at Ellis Island only with the permission of the Labor Department. They are coördinated among themselves and they necessarily make contacts at the Island with the Immigration Service and the Medical Service. Of course, they must also maintain wide community contacts, both national and international. They stand as a liaison group between official agencies on the one side and community agencies on the other, coördinate their work among themselves and with the official agencies, at the same time, maintaining the broadest sort of contacts with all of the communities of the world.

Their general purpose is to assist the detained alien, bearing always in mind his social and human needs; to act as a liaison organization between the alien, the Government and the communities from which he comes or to which he goes; to serve as a medium between him and his relatives and friends outside; to minister to his spiritual needs; and to maintain religious services.

SOCIAL DIFFICULTIES IN ENFORCING THE LAW

In the application of restrictive immigration law, aliens who come to Ellis Island are by no means always immigrants, that is, people seeking a permanent home in the United States. If this were so, the social and welfare problems would be simplified. The aliens concerned, however, present many difficult features. In addition to real immigrants there are visitors, persons returning to the United States and seeking entrance with reëntry permits; persons in transit; stowaways; workaways; deportees (both voluntary and forced for various causes under warrants of arrest); crews of foreign vessels or crews of American vessels who are not naturalized, and other types of aliens. All of this creates not only diversity but difficulties of all kinds, and the social problem presented is often very intricate and difficult of management because it is not purely a social problem, but also has its official relationships and must be solved under the more or less rigid limitations of law, which makes the whole situation always more difficult.

These social and welfare agencies do not neglect what might be called friendly services to the alien. They are primarily devoted to serious study of his case in all its ramifications in order to help the alien into the community to which he is going with the establishment of all his community relationships on a more or less satisfactory basis. But, in addition to this, they are very useful in supplying recreational and similar facilities to the alien while he is detained on Ellis Island. This is a service of much

*Those marked with an asterisk are full-time agencies.

importance, particularly at Ellis Island where persons are detained for indefinite periods, practically as prisoners, under conditions which are naturally most trying to them. It will be observed that every effort is made to supply wholesome and pleasant recreation, as well as facilities which are destined ultimately to help the alien in many ways. Indeed regular educational facilities, where necessary, are maintained at Ellis Island for the training of children and even of adults.

TYPES OF PROBLEMS

Some brief examples of the problems presented will show their variety and their difficulty. In quoting these examples it must be understood that the restrictive immigration law is not without all elasticity in its application. In certain cases provision is made for appeal. There are time limitations in many cases beyond which it does not operate. Moreover, there are provisions in the law whereby under exceptional circumstances the alien may be admitted under bond. There are some other arrangements which help in many ways and under exceptional conditions prevent undue hardship and injustice. These exceptions, however, are few in number and available only under strict limitations.

One of the most distressing and as well one of the most common examples concerns what are known as reëntry permits. An alien may be domiciled in the United States for many years without acquiring citizenship, usually through carelessness and ignorance. He marries, goes into business and rears a family of children who are American born, and therefore Americans. Then for certain reasons he may decide to visit his mother country. He goes abroad with a reëntry permit which clearly states that this does not entitle him to reëntry into the United States unless he satisfies the requirements of the law, including a medical examination.

On his return he may be found suffering from some serious mental or physical defect and he is so certified by the medical staff to the Immigration Service. He therefore becomes subject to deportation under the law. Comment on such a situation is needless.

Another example is a similar alien who acquires a domicile in the United States, marries, goes into business, rears a family, which is American-born and therefore Americans.

Then the depression comes on, his business goes to pieces, and he determines to take his family back to his native land, and voluntarily requests to be returned home. His children do not speak his native language, they have never been in his native country, they have grown up and made friends in America and have always considered themselves, as indeed they are, American citizens.

Imagine this family going back to their father's native country under such conditions!

Another alien is found in this country in violation of law. He is arrested, taken to Ellis Island pending deportation. He may have been in this country a long while. He has a family, business and numerous relationships in America, and yet, perhaps, through certain circumstances he has failed to comply with immigration law. He is subject to deportation to his native land, with a family and all his business interests in America.

Or it may happen that an incoming alien, a real immigrant, with a family of three or four children arrives at Ellis Island and is subjected to medical examination.

The entire family is passed except one child who is found to be suffering from a mandatorily excludable condition, and under the law must be deported. This, of course, disrupts a family and places upon a family with limited means a problem of first magnitude. Such a thing, especially in days which have gone by, was by no means so unusual. The institution of medical examinations at many ports in Europe has served materially to reduce these distressing

instances. One may imagine in a feeble way the effect of such a thing upon such a family. The distress is obvious and the need for help is urgent.

These and numerous similar examples illustrate the work which devolves upon the social and welfare agencies at Ellis Island. One can readily see that of necessity they must maintain contacts international in their scope, and must be ready to meet problems of the most varied character, which possess both official and non-official aspects.

Nothing has been said of the difficulty often encountered in securing passports to return people to their native land, and since the World War with the change which has taken place in the boundaries of many European countries, this difficulty has been gradually increased. Nor has anything been said concerning the attempt on the part of aliens, through legal methods, to avoid deportation. This likewise increases the difficulties of the case.

Enough has been said to show that the alien who comes under the provisions of restrictive immigration law, and goes to Ellis Island, is by no means a neglected individual. Everything possible is done to make his stay at Ellis Island bearable and to mitigate his lot as much as possible. The law is enforced with sympathy and with intelligence, although to many people it entails hardships.

Much of the criticism made against Ellis Island is either inspired or made through ignorance. All agencies at Ellis Island, both official and non-official, fully realize the hardships which are entailed in the enforcement of a general law of this character and do everything in their power to assist the alien and under the circumstances and conditions to make his lot as easy as possible.

In keeping dangerous communicable diseases from breaking through our borders in 1933, the quarantine officers of the U. S. Public Health Service inspected 15,007 vessels, 710,982 passengers, and 1,086,204 seamen, and medical inspectors examined 680,152 alien passengers and 783,377 alien seamen at ports of entry.—*U. S. Public Health Service Report, January, 1935.*

THE CHALLENGE TO EDUCATION

"A liberal education is not only one which is based upon a true concept and understanding of freedom but it is one which prepares for freedom—freedom from narrow and self-seeking selfishness, freedom from meanness and hypocrisy, freedom from malice and antagonism whether personal, group or national, freedom from willingness to exploit or impose upon one's fellow men."—*From Nicholas Murray Butler's Address at Installation of Dixon Ryan Fox as President of Union College, Schenectady, New York, October 12, 1934.*

Nursing Care for Relief Board Clients

By RUTH W. HUBBARD, R.N.
Director, Visiting Nurse Society, Philadelphia, Pa.

Many readers have asked us "How are other cities handling nursing care under F.E.R.A. Rulings No. 7?" Here is Philadelphia's answer.

LATE in November 1933, the State Emergency Relief Board of Pennsylvania established the policy of providing medical care and nursing for its clients in accordance with Rulings No. 7 of the Federal Emergency Relief Administration. The essentials of the plan were to provide good medical care including nursing, at moderate expense to recipients of relief, augmenting rather than superseding existing resources, and to maintain existing relationships between physician and patient as well as within the several professions involved. Certain limitations were placed upon the amount and kind of service to be offered. A schedule of fees was established. Care was offered to clients only in their own homes or at the doctor's office. Patients accustomed to using clinic services when ill were expected to continue this plan. No hospital expenses were honored by the State. Each physician, dentist and nurse undertook to give service throughout the duration of the illness although this might entail more visits than the State could honor. A State medical director was appointed to administer the program and Rulings No. 7 called for the establishment of State and County advisory committees of the several interested professions—medicine, dentistry, nursing and pharmacy. Members of these four groups licensed or registered to practice their professions in the State of Pennsylvania were eligible to participate in the program. Authorizations for medical care were issued in writing by the local County Relief Board. Authorizations for dental and nursing care and for prescriptions were issued by the County Relief Board on the recommendation of the physician.

ESTABLISHING COMMITTEES

At once the State organizations of the respective professions formed State and County advisory committees who reported themselves ready to assist the State Medical Director and the local County Relief Boards in a professional advisory capacity in the development of the plan. In Philadelphia County this Committee has met regularly. The Pennsylvania State Nurses' Association effected this set-up through its districts, forming District Advisory Committees as well. The State Nursing Advisory Committee promptly submitted several recommendations to the State Medical Director. It was urged that the professional qualifications of the participating nurses be verified, that whenever possible existing public health nursing agencies be used to render the service while efforts be made to develop such service in counties where it did not exist, and that professional supervision be accepted as a fundamental part of the program. These recommendations being accepted by the State Medical Director, the local County committees then proceeded to work out their program with their local County relief boards. By the first of the year most of the counties were offering their clients medical care, though some few delayed in accepting the opportunity.

PHILADELPHIA'S PLAN

The situation in Philadelphia has not been typical of the State as a whole. The city covers the county and as this is the area covered by the Visiting Nurse Society it was at once possible to offer nursing care to all County Relief Board clients. The State, however, has many more rural than urban counties and

these areas have much territory uncovered by nursing agencies. The problem of providing adequate nursing service on a visit basis with no allowance for transportation has been difficult. Each County committee attempted to select certain nurses strategically placed geographically, who were prepared and willing to answer calls for nursing service. This has been achieved with moderate success. In some areas where the residents were not accustomed to a visiting nurse service the calls have been few in number.

Philadelphia County has a well organized County Relief Board. At the time that the medical relief program was added, December 15, 1933, there were some 60,000 families on direct relief. At the present writing (January, 1935) the number has risen to 74,000. All of these individuals were eligible for medical care.

There are in the City of Philadelphia approximately 3,200 practicing physicians. All of these physicians were eligible to assist in the program.

The Visiting Nurse Society has a staff of 120 nurses. This Society was accepted by the County Relief Board as the agency to render nursing service. The C.R.B. undertook to administer the program by establishing an Administrative Committee which would be directly responsible to the C.R.B. This Committee was composed of the chairman of the four professional County Advisory Committees together with representatives from other interested groups (Department of Health, hospitals, dispensaries, medical social service). The C.R.B. appointed a medical social worker to administer the program and act as medical supervisor. From the beginning this Committee has met regularly each month and has been responsible for the policies governing the development of the local medical relief program under the State regulations. It has turned to the various professional advisory committees through their chairmen for assistance in establishing adequate and sound care. It has asked these committees to be responsible for the standard of service to be rendered its clients and for the supervision of this service through a review of the monthly bills and through such further means as might be deemed necessary.

As the program developed it became apparent that the volume of work being asked of certain of the committees was too great for satisfactory handling by a volunteer group. Therefore, in the spring a physician was appointed to the C.R.B. staff to act as a liaison person between the C.R.B. and participating physicians. At the present time, recommendation has been made to the C.R.B. that some assistance be secured through a part-time dentist in the same manner.

WORKING OUT OF THE PLAN

During the first ten months of the program the Visiting Nurse Society assisted the C.R.B. in the authorization of medical care. It was necessary to visit each home which requested medical care before issuing authorization. Naturally these visits had to be made promptly. A temporary working agreement was evolved between the two agencies for this work. As the program developed the amount of authorization work necessary increased rapidly. After several months both interested agencies felt it wise to have the authorization work carried entirely by the C.R.B. Therefore, in October this was arranged and at the present time the Medical Supervisor has a staff of nine nurses who are engaged in making investigatory visits and issuing medical authorizations. It is the ultimate objective of the C.R.B. to integrate this in the hands of the district visitors. At the present time their case loads are so great that it is impossible for them to render the prompt service which requests for medical care demand.

In undertaking to supply nursing service to clients of the C.R.B. whose physicians desired it, the Visiting Nurse Society undertook to offer the same high standard of professional service which it offers to its other patients. All participating groups agreed to render full service to their patients even though this would require more visits than were allowed by the State regulations. Only

those visits on which nursing care was given were chargeable to the C.R.B. The authorizations were made on a family basis. If two or three of a family were ill with the same diagnosis, both physician and nurse were expected to give the necessary care to all members while charging for a single visit. A maximum of ten visits in which nursing care is given may be made on any one authorization slip. Within the last few months the State Medical Director has approved the requests for re-authorization for nursing care in certain types of acute illness, such as pneumonia where the prognosis is good and where intensive nursing care is required. A total of six visits only has been allowed to chronic patients. These are primarily for teaching purposes. The policy has been to offer service to the prospective worker who is acutely ill rather than to give extended care to the chronically ill person who will probably not be employable again. It is required that the maternity patient receive adequate prenatal supervision as well as postpartum care. The Society has found it impossible to offer service at the time of delivery routinely as the delivery service is an expensive one. The fee per visit throughout the State is eighty-five cents, which is a loss of seven cents per visit to the Visiting Nurse Society. A brief review of the statistics shows that during the year each case has received approximately eight and a half visits, half of which have been nursing care visit and half supervisory and instructive visits. An average of slightly under three hundred patients per month have received about twenty-five hundred visits. Since about half of these visits were chargeable, the Society has received about $1,000 a month.

During the spring of 1934 there was a severe epidemic of measles accompanied by its complications in Philadelphia. This greatly increased the work of the Visiting Nurse Society among clients of the C.R.B. as well as among other groups of patients. Now at the end of the first year the service is somewhat more stabilized. Many of the problems which confronted us in the beginning are solved. It has been interesting to observe that a number of problems which confronted the Administrative Committee arose because of misunderstanding on the part of individuals who were participating in the program. Since the nursing group participated as an organization this type of problem did not arise.

BETTER SERVICE

It is the feeling of the local nursing group that patients have had more adequate medical care than usual. We do not believe that clients of the C.R.B. who needed physicians have gone without them. Without being able to offer sustaining figures, it is our feeling that many persons needing nursing care have received it who formerly would not have done so. A rough analysis of the types of illnesses cared for shows them to be predominantly acute in character. During the early winter and spring upper respiratory infections and communicable diseases made up the greater part of the work. The summer and early fall saw an increase in maternity work, although the total case load dropped. There has been comparatively little time wasted in unproductive visits as far as the Society is concerned. Many health needs have been discovered which need intensive follow-up, but limited time and staff have so far precluded accomplishing these needs.

ADDED STAFF

In Pennsylvania the use of C.W.A. workers by private agencies was not approved. Therefore, when the requests for nursing care for clients of the C.R.B. became excessive in the spring, it was necessary for the Visiting Nurse Society to add temporary people to its staff to carry the work. It was fortunate in being able to secure former students and former staff nurses who were able to fit into the program on short notice. During the year some twenty people have been members of the staff for periods ranging from two to six months in this way. When the Visiting Nurse Society discontinued the assistance it was giving the C.R.B. in the

making of authorization visits, the Board recruited its own staff from the public health nursing group asking the County Advisory Committee for professional recommendations. (It is not within the provision of this paper to discuss the work of the C.W.A. nurses in Philadelphia County. It may be interesting to our readers, however, to know that approximately two hundred nurses received, on an average, two months of work during the year on such projects in this County.)

NEED FOR BETTER INTERPRETATION

Early in September the sixty-seven County Nursing Advisory Committees were asked to submit to the State Chairman reports of the progress of the program to date. These reports and their accompanying recommendations are especially helpful in studying the program on a State-wide basis and in determining its success. It is very apparent from the number of times that the need for greater coöperation was mentioned that in the State as a whole it is important for public health nursing to work for better understanding in its relation to the medical profession and for wider knowledge of its program among lay people. In general it can be said that everywhere the need for prompt reporting of acute conditions and early reporting of prenatal cases by the C.R.B. worker is important. The problem of transportation has been a prominent one in the State, though it has not raised difficulty in this County.

PROBLEMS IN THE RELIEF PROGRAM

It has seemed to those of us associated with the program that one outstanding lack in its provision has been the absence of any allowance for payment of health supervision and health work by physicians, dentists and nurses. There is no way in which a physician can submit a bill for any preventive work which he does. All the dental work is emergency and the excellent opportunity for constructive work with the young people is lost. The health supervision and health teaching which a public health nursing organization can give must be entirely at the expense of the association rather than the State. The State Medical Director is conscious of this lack and it is hoped that with the experience of a year it may be possible to include this aspect of the work in the program.

A serious problem for Philadelphia County has been the fact that the program was administered on a State-wide basis without the establishment of a budget for each County. There is wisdom in State-wide administration, but it has been difficult for each County to develop its program soundly and be entirely in the dark as to how much it could properly spend.

Restrictions concerning the limitations of service have been difficult to meet and it is felt most important that some extension of the program for the care of the ill is needed. As the work becomes more stabilized and the set-up for adequate supervision of all interested groups is more complete so that unsatisfactory service is eliminated, it may be possible to alter some of these restrictions.

It has been apparent to the County Advisory Committees throughout the State that this program has been most satisfactorily handled where a local nursing organization has carried the nursing service. It is evident that where such an organization was absent it has not been possible for the nurses in the county to supply such service satisfactorily on a visit basis, both from the point of view of the patient and the nurse.

In summarizing it may be said for Philadelphia that the inclusion of a positive health program, more complete use of the nursing service by physicians, a broader policy governing the amount of nursing care to be given acutely ill patients, the development of a somewhat more adequate record system, and the adoption of a cost-per-visit basis of payment should make the service more satisfactory to the C.R.B. client, the C.R.B., and the Visiting Nurse Society. It has been the feeling of the Society that the experience of the year has been a valuable one. Many physicians who were formerly

unacquainted with the Society have learned to know its service and to request it for their patients. An opportunity has been given to work closely with other large service organizations in the community and to develop satisfactory relationships in behalf of their clients. The Society has found itself able to adjust to new and emergency needs, aud while this adjustment naturally disturbed the association's program it has brought with it excellent advantages. As a member of the Administrative Committee of the C.R.B. it has seemed to me that the professions involved in the rendering of these services have come to understand each other very much more adequately during the year that they have sat on this Committee, and it is my feeling that the administration of a medical relief service to clients of the C.R.B. through a Committee of this kind, depending upon the County Advisory Committee for their professional advice, has been the keynote of the strength of the program in Philadelphia County. It also presents opportunities for extensive development of the program and more satisfactory service in the future.

More About Medical Relationships

SINCE the publication of the report on Medical Relationships in Private Public Health Nursing Agencies,* several agencies have expressed a wish to hear more about concrete methods toward successful coöperation with local medical societies. We have the opportunity to describe three: that of the Brooklyn (N. Y.) Visiting Nurse Association and the Medical Society of the County of Kings; the Detroit (Mich.) Department of Health with the Wayne County Medical Society; and the Visiting Nurse Service of the Jersey City (N. J.) Chapter of the American Red Cross and the Hudson County Medical Society.

All three of the agencies (2 private and one official) made use of the monthly bulletin of the medical society which goes to all members in the county. The Brooklyn V.N.A. has a quarter of a page notice in December, for instance, (although this has become a routine) reading as follows:

VISITING NURSE ASSOCIATION OF BROOKLYN

A Visiting Nurse is as Near as Your Telephone

Call headquarters at
138 South Oxford Street
STerling 3-7420

Cost of general nursing visit....$1.05

Cost of special hourly nursing....$1.50
The service is free to those who cannot pay all or part of the cost

This notice appeared under a message to the medical profession from the Medical Society's *Committee on Nursing* which read as follows:

Doctor: Are You Giving Your Pneumonia Patient at Home Every Advantage to Respond to Your Treatment?

I. One of the advantages of hospital care is the nursing service to carry out your orders.

II. Home care may be made more efficient with the assistance of a nurse.

III. Full-time nursing may not be practical or necessary.

IV. Will a nurse increase the welfare of your patient?

There are the following types of nursing service:

1. Graduate nurses, male and female, for hourly appointments. To patients with certain industrial insurance and to those who cannot pay all or part of the cost, free nursing visits are available.
2. Nurses' fees can be adjusted to the patient's circumstances.
3. Visiting housekeeper under home relief to care for the family when the mother is ill.
4. For 24-hour care, an improved service by three nurses, each on eight-hour duty, with no increase in the cost to the patient for the 24 hours.

For further information telephone
the County Society office,
STerling 3-6900

No Patient of Yours Requiring Nursing Care Need Go Without a Nurse's Service

In Detroit, the Department of Health

*See November, 1934, PUBLIC HEALTH NURSING.

sent the following routine communication to the Bulletin of the Wayne County Medical Society:

IMPORTANCE OF NURSING SERVICE IN CARE OF PATIENTS HAVING PNEUMONIA

During the period of October, 1933, to March, 1934, 2,566 patients having pneumonia were reported. Of this number of patients, 729 or 28 per cent died. Among these pneumonia patients, 500 were given nursing care by the Visiting Nurse Association; thirty-two or 6.5 per cent died. This record is a very commendable one which will be appreciated by all physicians in Detroit. The fact that nursing service was secured indicates that the 500 patients were also under good medical care.

The implication may also be made that of the 2,566 patients having pneumonia, many of them had little or no medical care. However, the value of good nursing in the treatment of pneumonia, particularly in its early stages, is recognized by all physicians.

The 500 patients attended by the Visiting Nurse Association last season is about double the number treated during the previous season. This increase in number of cases treated was due to the effort of the Public Health Committee of the Wayne County Medical Society last year to increase the nursing care of pneumonia cases in order to decrease the number of fatalities.

There followed a statement on current disease statistics and the report is signed by the Commissioner of Health.

In Jersey City, the Director of the Red Cross Nursing Service sent the following letter to the Secretary of the County Medical Society, prefaced by a list of the members of the Medical Advisory Board of the Nursing Service:

My dear Dr. B——:

I am writing to you as Secretary of the Hudson County Medical Society to ask if you will bring to the attention of the members that the Visiting Nurse Service of the Red Cross is very desirous of offering its services to them. This service is prepared to give nursing care and treatment to any of their patients in their homes and under the respective physician's direction. (Only two visits may be made to a patient if a doctor is not in attendance—one to ascertain the patient's condition and the other, to find out if a physician has been called.) All types of cases are cared for, by graduate registered nurses only. This is done on part-time basis—the nurses stay in the homes only long enough to give the care or treatment prescribed by the doctor.

For those patients who can pay, a charge is made—$1.00 per visit for the ordinary case—$1.25 for maternity care. Slightly higher rates are charged for special treatments (*i. e.*, high colonic irrigations) and definite appointments. Part pay and free service is rendered to those patients unable to meet the full cost of the visit with the exception of relief cases which are cared for through the Medical Center; also, the policyholders of the Metropolitan Life Insurance Company who are cared for by the company's own nurses. The John Hancock Insurance Company pay us for care to their weekly policyholders so no charge is made them.

The nurses are on duty from 8:30 A.M. to 4:30 P.M. except Sundays and holidays. Calls to be made in the forenoon must reach the office by 9 A.M. Any calls reported by 1 P.M. will be visited the same day unless otherwise specified.

The physicians are cordially invited to make any suggestions or comments at any time to the Director or the Medical Advisory Board and asked to report any dissatisfaction or unethical procedure on the part of her staff directly to her so any misunderstanding may be avoided.

It is our desire to be only of assistance to the physicians. The staff nurses understand that absolutely no suggestions be given as to preference of any physician, and clinics are to be used only when other medical care cannot be secured.

I would like at this time to thank the physicians for their fine coöperation in the past and trust the future will find our service meeting a need for the welfare of the community and a real help to the medical profession."

Have you worked out other successful methods of interpreting your service to the medical profession? What have been particularly constructive ways of using your medical advisory committee? Won't you share your experience with others through the pages of this magazine? The editors will welcome all suggestions, no matter how simple they seem to you.

Undergraduate Affiliation in Public Health Nursing in a County

By HARRIET B. COOK, R.N.

Educational Supervisor, Monmouth County Organization for Social Service, New Jersey.

AFFILIATED courses in public health nursing for hospital students have been for a long time part of visiting nurse association and public health nursing programs in our larger cities. There is little precedent, however, for such an experience in a rural county doing a very generalized piece of health and welfare work.

Monmouth County is about 440 square miles in size and has a population of 150,000 people. Because the county is quite health-conscious, it has more than the usual rural resources for health and welfare work. There are fifty public health nurses employed in eight or nine one- to three-nurse local public health organizations, and those with the Monmouth County Organization for Social Service which serves other parts of the county and acts as a centralizing unit coördinating all the local agencies. The M.C.O.S.S. officially represents the state and county for certain health and welfare services. These it re-delegates to local units to prevent duplication. In return for what the local organizations do for the M.C.O.S.S., it gives them opportunities which small units might not ordinarily be able to get, such as certain types of clinics, advisory service, educational opportunities, etc. As a result there is a fine solidarity of feeling among all.

Also Monmouth County has two general hospitals with training schools for nurses and well equipped dispensaries, a county tuberculosis sanatorium, a county welfare house for the indigent, aged and chronics, a shelter for the homeless and incorrigible children pending action of the juvenile court or placement in foster homes, a state hospital for mental diseases and a tuberculosis preventorium for children. These are widely scattered throughout the county, making it necessary for many patients to travel as much as forty or fifty miles to go and return from the dispensaries.

With an organization to give direction and supervision to students an affiliation in public health nursing for the schools of nursing appeared to be a logical development.

A year and three months has now elapsed since the affiliation began. Nineteen students from the Fitkin Memorial Hospital Training School for Nurses and sixteen from the Monmouth Memorial Hospital Training School for Nurses have completed their course. All but five of these students have their homes in Monmouth County. Their enthusiasm for public health nursing has made them good interpreters to parents and friends who in many cases knew little about their county health and welfare activities.

REQUIREMENTS FOR AFFILIATION

In our plan we stated we would accept seven or eight students at a time for a three months' period from the Fitkin Memorial and Monmouth Memorial Schools. These students were to be in good health and high school graduates and in their senior year of training. Ability to drive a car was considered an asset.

These requirements have been met in almost every detail. A few students who had had each type of service in their training schools came to their affiliation the latter part of their junior year in order to make it possible for all students to have public health nursing experience and yet not to have more in the field at one time than could be given experienced supervision. The three months period was changed to twelve

weeks in order that all services at the hospitals might change on a Monday morning. One exception only was made to the high school graduation requirement and will not need be made again as both hospitals now require four years of high school. Chest rays and thorough physical examinations were given each student prior to entering her affiliation. Preliminary questionnaires revealed that one or two from each group could drive a car. This made it possible to give these students experience in the more rural areas.

LIVING CONDITIONS

Students retained their residence with breakfast and supper at their respective hospitals except for two weeks when they were at the county tuberculosis sanatorium. From there they were returned each Friday night to their hospitals in order to be available for Saturday morning classes and were taken by car again Monday morning to the sanatorium. Lunches were packed for them by their hospitals except for the two or three from each group who were near enough to return to their hospitals for lunch. Since dinner in both hospitals was at noon, this necessitated additions at times to the evening meal to make their diet balanced and adequate.

TRANSPORTATION

This was one of the most difficult factors of our planning. Most of the students were Monmouth County girls. For this reason it did not seem advisable to place them for work in the community in which they lived. Also certain units of work were better organized and had more experienced supervisors than others. The two hospitals are both located on the extreme eastern part of our county, making them quite inaccessible to certain sections.

These difficulties have had to be met differently with each group. Three public health nurses living in the vicinity of the hospitals used their own cars to go to and from their respective health centers. They have been generous in taking certain students to points where they can be transferred to their own supervisors' cars. Extra gas was allowed these nurses by the M.C.O.S.S. Lay volunteers were good about taking students to and from the tuberculosis sanatorium at week ends. In one case it was necessary to allow one student whose home was near her field to remain in her own home except for weekly visits to her hospital. During vacation periods and holidays special arrangements had to be made. Last winter, blizzards also made some complications.

FINANCING

The hospitals continued to bear the expense of residence, board, laundry, and uniforms including black ties, and belts instead of bibs and aprons. The M.C.O.S.S. furnished gas and train fare, uniform coats, hats, note books, books for required reading, and magazines, experienced supervision, lectures and other educational guidance.

AIMS OF EXPERIENCE

The objectives of the National League of Nursing Education were kept very much in mind. For brevity we stated them as follows:

To give student nurses in training an opportunity to gain an understanding of the patient in the home prior to and after hospitalization that they may appreciate the patient's mental and physical needs while in the hospital and later in whatever field they may continue their interests.

To give the student an opportunity to get experience in the prevention of disease and in those types of nursing that the hospital now so rarely sees.

To increase the student's understanding of the public health aspects and opportunities in nursing.

FIELD EXPERIENCE

Each twelve weeks, the new group of students reported at the headquarters of the M.C.O.S.S. Here they met their educational supervisor, field supervisors, and the students from other than their own hospitals. The educational supervisor explains to them as a group the plans for their experience, gives them mimeographed forms for charting their experience, shows them their reading shelves, etc. This takes about one and

one-half hours. Then their supervisors take them to the health centers at which they are to have their field experience.

We have had very much in mind that the whole experience is merely an introduction to public health nursing and we do not attempt to crowd everything into the first week or two.

The remainder of the first day the students are given an opportunity to become acquainted with their health center and to observe their supervisor in the field visits. For the first two or three weeks the students assist at clinics, make visits to observe and assist their supervisors. They do alone only that kind of work that is more or less routine or those types of bedside cases in which they have had experience with their supervisors. Gradually, as the nurses show ability to recognize problems and to keep their supervisors informed, they are allowed responsibility for certain types of educational, baby welfare, prenatal, postnatal, school, and old age pension supervisory visits. Care is observed in giving them special cases to study that they may select those in which some improvement may be expected in the short period of time they are carrying the case.

Two weeks of the twelve-week period are spent in the county tuberculosis sanatorium. This experience is placed as near the end of their stay as possible that they may have a better understanding of the homes from which the tuberculous patients come. Two students, one from each hospital, are assigned to the sanatorium at a time, thus giving them an opportunity to talk over their hospital and field experiences. They say they find this exchange of ideas of special interest.

Experience sheets, kept by each student, are gone over regularly. Occasionally it is necessary to change a student to another district in order that she may get a more varied experience. This is not thought wise, however, unless there are important gaps.

LECTURES AND CLASS WORK

Most of the twelve lectures have been held Saturday mornings in the M.C.O.S.S. headquarters. A few, however, are held in different types of local health centers where equipment is more adequate for certain demonstrations. The director of our public health nursing work, our district health officer, supervisor of home life department of the State Board of Children's Guardians, educational supervisor and other supervisors have given the lectures, which last one hour. The remainder of the morning is given over to demonstrations, case reports, county welfare map making, review of certain magazine articles, individual conferences, etc.

OBSERVATIONS AND VISITS

The students are taken from their field for planned observations of preschool play centers, home hygiene classes, and to visit the state hospital for mental diseases in our county, the welfare house for chronic patients and indigent aged, the children's shelter and the tuberculosis preventorium at Farmingdale. Mimeographed questionnaires regarding these visits and observations are given each student to guide her in her visits. These are carefully discussed later. It quite frequently happens that the nurses have opportunities to assist in the admission to or follow-up from these institutions.

REPORTS

Reports are kept as simple as possible. At the end of each twelve-week period a quiz is given each student. The grades for these examinations are averaged with those for their social case studies, dispensary case study, reports on institutional visits, magazine articles, welfare maps and reading. These appear as their theoretical grades. Each supervisor and the superintendent of the county tuberculosis sanatorium keeps an efficiency record which has evolved as a result of this affiliation. These are averaged for their efficiency record. The average of the theoretical and efficiency grades appears as their final grade. These three grades with the division of time in hours spent in field work, in the

tuberculosis sanatorium, and theoretical work are all that appear on the final report sent to their respective schools of nursing over the signatures of the director of public health nursing and the educational supervisor.

STUDENT EVALUATION OF AFFILIATION

In order to evaluate adequately this experience in such a rural field with such a generalized public health program, we have asked each student as one of her final quiz questions to state in not more than fifty words just what her experience in the public health affiliation has meant to her. Replies have brought out in each case very much the type of thing that we hoped they would. We quote one from a student from each school of nursing:

"My experience in public health has helped me gain a lot of knowledge that might have taken years to gain otherwise. I have found that I have a more personal feeling towards my patients, which I never could have obtained in the hospital surroundings. I have learned about county resources and how to detect problems in the home so that these resources may be used to the best advantage. In doing procedures I have found it necessary to adapt new methods and adjust my technique to suit the situation. I have gained a health point of view and learned a great deal in reference to the prevention of diseases and conditions. While making contacts I realized the necessity of making a good contact through being courteous and interested. It has been much easier to teach health habits and nursing care while in the field than it is in the hospital."

(Monmouth Memorial Hospital.)

"Three months of public health have taught me the value of public health nursing. Formerly a public health nurse signified school work and a convenient transportation for patients to clinic. I realize the importance of preventive measures, the value of the word 'coöperation,' the necessity for records and the various types of problems which confront a public health nurse in a generalized program. I have been able to observe the type of homes which patients in the hospitals come from, their customs and beliefs, the foundation of some of their ideas, and how little the lay people know about the things which I as a student nurse recognized as simple and thought that everyone knew. It has stimulated within me a desire for more knowledge and the value of reading. It has taught me to be more tactful, more patient, more explicit in directions and explanations, and sympathetic.

I have found out how much responsibility a public health nurse has and how easily, and often unjustly, she is criticized."

(Fitkin Memorial Hospital.)

Photo by Wendell MacRae
Courtesy of Rockefeller Center Weekly

"LITTLE RED"

A replica of the first tuberculosis sanatorium in America. Dr. Trudeau's "Little Red" constructed and exhibited by the New York Tuberculosis and Health Association in Rockefeller Plaza, New York City. The buildings of Rockefeller Center and Radio City are in the background. The bronze gentleman with fire in his hand peering over the roof of "Little Red" is Paul Manship's conception of Prometheus. The N.O.P.H.N. offices are on the left hand side of the building and correspond to the upper windows of the wing just visible on the right.

The School Public Health Nurse a Health Educator *

By ERMA NANCY SCRAMLIN, R.N.
Ball State Teachers College, Muncie, Indiana

SOME years ago, the National Education Association drew up a list of objectives upon which to build the fundamentals of our educational system, and the first of these objectives was health—not only physical health, but mental health, emotional health, and social health. It is a broad objective, and in the course of the past decade it has had many growing pains. We have advanced from "the clean tooth never decays" stage to the point where we are requiring licenses in health teaching from recognized schools. The school nurse is one of the outgrowths of this objective. What is her contribution as an educator to the problems of the public school?

The field of the school nurse is as varied as that of the teaching profession. Prior to 1929 there were in the United States fewer than 7,000 school nurses and only 4,000 of these full-time. The present school nurse has under her charge from 500 to 10,000 students, with an average of 5,000. Her territory may include one or thirty schools, twenty blocks or twenty townships. Her students may represent native American stock, or twenty creeds and nationalities. The employer of the school nurse may be the board of education, the board of health, the visiting nurse association, a Red Cross chapter, or a combination of these, and as a result, her work may be dictated along varied lines. It may be largely teaching of health classes, or it may be wholly administrative and concerned with physical examinations, control of contagion, correction of defects. She may have the enthusiastic backing of the medical men in her territory, or her field of activity may be limited by their lack of understanding of her objectives.

Whatever set-up she finds, the nurse who chooses this field is increasingly in need of advanced preparation for her work. At least a year's training in public health is desirable. Experience in generalized visiting nursing service is of unquestionable value in giving her a social as well as a clinical viewpoint. In addition to being a specialist in the field of health, the nurse in a school situation should have some knowledge of the laws of learning and an appreciation of the underlying principles of education if she is to function as an educator. She should be able to evaluate her school, whether the set-up is formal or progressive, or contains some of both elements. She needs to understand what her school is trying to accomplish in order that she may coördinate her own program with that already in operation.

HOW THE SCHOOL NURSE SHARES IN EDUCATIONAL WORK

However varied her program, inevitably it will incorporate to some degree the following kinds of educational work.

She will be called on to assist her schools and individual teachers in determining their health needs. Communities vary in their needs with size, economic status, and racial make-up. Age, home conditions, and present habits will determine some needs. Others may be revealed through routine procedures. For instance, physical examinations are perhaps one of the finest means of giving the teacher and the nurse accurate information on which to base their work—

*Paper read at the meeting of the Indiana Tuberculosis Association in Indianapolis, April, 1933.

the nutritional status, which so well reflects the hygienic background of the home; the percentage of visual, hearing, dental, and other remedial defects. Health questionnaires filled out by the parents are good sources of information. Home contacts are invaluable. Whatever means are employed, the set-up should be flexible enough to operate from year to year in determining changing needs.

A second important educational contribution of the school nurse should be that of serving as advisor to the teachers. The teaching profession is probably one of the most harassed in the world. However eager a teacher may be, it is humanly impossible for her to keep abreast of all the topics in which she is interested, and almost no field of information changes so rapidly as that of health. Scientific research today renders yesterday's dogma obsolete tomorrow. The nurse may make one of her most valuable contributions that of acting in an advisory capacity to the teachers, keeping them posted on the best bibliographies, and assisting them in evaluating health books and other sources of health information.

She may be of further assistance in aiding the teacher to find situations for teaching health. We are changing our methods of teaching health along with other methods in education. Gold stars are giving way to new orders. We understand now that learning is never single; too frequently in the past we taught undesirable habits along with some of our well intended awards. We are coming to recognize more and more that health is a matter of everyday living, and that by giving the school child an opportunity to live healthfully during the school day, we are encouraging habits of a desirable nature with much more surety than by awarding ribbons for dubious performances of set duties. Having a supply of fresh cool water and drinking cups in a school room and giving the children opportunity to drink, we believe more fruitful in creating desirable habits than several posters proclaiming the value of six glasses of water daily. The nurse, then, should be prepared to assist the teacher with suggestions for increasing opportunities for living healthfully. Older students may be taught the reason for certain desirable health practices, but to talk health to young children is a questionable investment of time. The term is too abstract for their comprehension.

Another contribution of importance is the opportunity for educational work with parents. We learn most readily when we are interested. In conferring with parents, the school nurse has the paramount advantage of dealing with the thing nearest the parent's heart—the child. If she is tactful, her field of influence here is almost limitless. She is the mediator between home and school; she may interpret the home to the school and the school to the home. The parent may feel a little freer with the nurse than with the teacher.

HER FIELD ALMOST UNLIMITED

In a wider sense the school nurse becomes a teacher and educator with every professional contact she makes, whether it be with student, teacher, or parent. Every physical examination should be done with the coöperation and interest of the student that it may become a teaching situation of value. Every inspection of an ill child and every case of first aid is a learning situation. The nurse who understands will create with every contact a favorable attitude not only toward the medical profession but toward finer ideals and standards of living in the child.

All the work in the control of infection, the investigation of absences, the correction of defects, the keeping of records, and immunization of children, presents some educational opportunities. It is difficult to evaluate a school nursing program by any cataloguing of duties. Much of what is accomplished will be in direct proportion to the preparation, the personality, the vision, and understanding of the nurse. An evaluation of health service can only be made over a period of years. The nurse who keeps in mind that health is not only

physical, but mental, social, and emotional as well, will leave in her wake not only finer bodies, but better homes, happier children and higher living standards.

In the present condition of things, the school nurse should be more valuable than ever before. She works with families and with individuals, with children and adults who have been facing the strain of economic readjustment. Her preparation and experience should make her particularly fitted to serve them—to encourage and help them to establish a feeling of security in themselves and in the future. The school nurse has opportunities for service that are comparable to few vocations. She may well become in the future more than a nurse or an educator, a potent and indispensable factor in the development of a finer community life. Her vocation gives her entry into any home. Neither creed nor nationality limit her field of service. If she has vision as well as preparation, she is particularly fitted to serve—to weave together the strands of community life—the parent and teacher, the home and school. And it is only by becoming united that we can hope for a solution to our present problems and a future that will mean physical and mental health for American childhood.

Public Health Nursing Programs in Public and Private Agencies—1932-1933

By LOUISE M. TATTERSHALL

Social Statistics Unit, Children's Bureau, U. S. Department of Labor

It is pleasant to see Miss Tattershall's material in our pages again, even though the initials N.O.P.H.N. no longer follow it. The report given here gives additional evidence of what has been happening in the field of public health nursing. The project of centralizing social statistics now under the auspices of the U. S. Children's Bureau is an important step in developing a scientific approach to our problems as it provides absolutely comparable figures from which to draw conclusions. We believe our readers will welcome the facts made available to us through the courtesy of the Children's Bureau and Miss Tattershall.

SOME interesting differences in the nursing programs of public and private agencies engaged in public health nursing and some changes that have occurred in these programs are revealed by the figures received by the U. S. Children's Bureau as a part of the project for the centralized reporting of social statistics. To make a comparison and analysis of the programs of these two types of agencies, it is necessary to have not only total counts for the two units—visit and case—but also the figures for a detailed classification of these two units. Figures in sufficient detail are available from 56 agencies—18 public agencies and 38 private agencies—for the years 1932 and 1933, so that a comparison can be made of the nursing programs of the two groups.

The reports from the agencies show the experience of 56 agencies located in 30 different urban areas* of 50,000 or more population in various sections of the United States. Of the 56 agencies, 18 are public and 38 are private.

*An urban area is usually a city or county. In certain instances, however, the area may include a city and its suburbs served by the agencies in the local council of social agencies

DIFFERENCES IN NURSING PROGRAMS OF PUBLIC AND PRIVATE AGENCIES

Distribution of Visits and Cases Under Care by Type

The accompanying chart shows for 1932 and 1933 the percentage distribution by type of service (health supervision, maternity, morbidity) for the public and private agencies, under (*a*) visits to cases and (*b*) cases under care, for each of the years 1932 and 1933. The percentage distribution of visits is based only on the number of "visits to cases," and does not include "visits in behalf of cases" or "visits to cases not seen." It is not likely that the inclusion of "visits in behalf of cases" and "visits to cases not seen" would have affected very much the percentage distribution for the various types of visits. In private agencies these visits form only about 7 per cent of the total visits in each year; in public agencies these visits were a larger proportion of the total—10 per cent in 1932 and 13 per cent in 1933.

In Health Supervision—From the chart some differences in the nursing programs of public and private agencies can be seen. In public agencies, for both 1932 and 1933, approximately one-half of the visits to cases and one-half of the cases under care for the year were in the health supervision service of infants and children of preschool age. In private agencies, about one-fifth of the visits to cases and about one-fourth of the cases under care were in this service.

In Maternity Service—Another difference between public and private agencies is that visits to cases and cases under care as part of the maternity service constituted slightly more than one-tenth of the total in each year in public agencies, whereas in private agencies more than one-third of the total visits and approximately three-tenths of the total number of cases belonged to the maternity service.

In Morbidity Service—The proportion both of visits made and of cases under care in the morbidity service was smaller in public agencies than in pri-

VISITS, CASES UNDER CARE AND AVERAGE NUMBER OF VISITS PER CASE, BY TYPE, FOR PUBLIC AND PRIVATE AGENCIES, 1932 AND 1933

Type of Service	Public Agencies				Private Agencies				Per cent change from 1932 to 1933	
	1932		1933		1932		1933			
	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	Public	Private
Visits to cases										
Health supervision	153,064	47	154,367	52	393,813	20	311,191	17	+ 0.9	—21.0
Maternity	37,573	12	34,111	12	732,310	38	691,067	39	— 9.2	— 5.6
Morbidity	130,729	41	106,386	36	823,762	42	782,661	44	—18.6	— 5.0
Total	321,366	100	294,864	100	1,949,885	100	1,784,919	100		
Cases under care										
Health supervision	66,967	48	51,686	43	100,158	27	100,091	27	—22.8	— 0.1
Maternity	16,133	11	13,464	11	108,436	29	107,252	29	—16.5	— 1.1
Morbidity	57,768	41	55,015	46	167,317	44	162,310	44	— 4.8	— 3.0
Total	140,868	100	120,165	100	375,911	100	369,653	100		
Average number of visits per case										
Health supervision	2.3		3.0		3.9		3.1			
Maternity	2.3		2.5		6.8		6.4			
Morbidity	2.3		1.9		4.9		4.8			

Based on reports by 18 public agencies in 13 urban areas and 38 private agencies in 26 urban areas

vate agencies. Public agencies emphasized health supervision service for infants and children of preschool age, but in private agencies this service was a comparatively small part of the nursing program.

Number of Visits Per Case

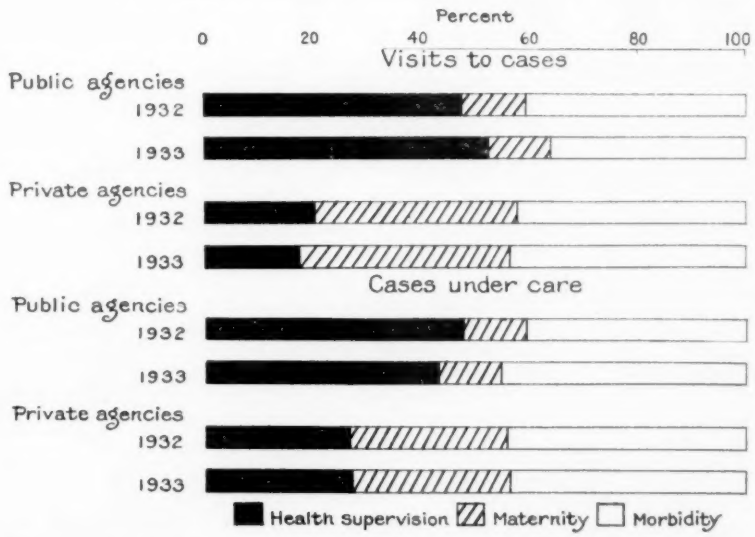
In Health Supervision—The average number of visits per case under care in the three services, as is shown in the table, brings out other differences. In 1932 the average number of visits per case in the health supervision service was 2.3 for public agencies and 3.9 for private agencies, indicating more intensive service for these cases by private than by public agencies. In 1933 the intensity of service was the same for both types of agencies since the average number of visits per case was 3.0 for public agencies and 3.1 for private agencies.

In Maternity and Morbidity Services—The average number of visits per case for both the maternity and the morbidity service of private agencies was more than twice that of public agencies in both 1932 and 1933, reflecting a pronounced difference in their nursing programs. The maternity service in public agencies is limited almost entirely to prenatal care, but in private agencies nursing care is given at the time of delivery and during the postpartum period, as well as during the prenatal period. Consequently the average number of visits per case for maternity nursing care is larger in private agencies than in public agencies. A few public agencies give a limited amount of bedside nursing care to cases under the morbidity service, but the nursing program of the morbidity service of most public agencies is health supervisory and instructive, visits being made only at infrequent intervals. In private agencies the nursing care of morbidity cases is almost entirely bedside nursing of sick persons, which requires a larger number of visits per case than is required for the health supervisory and instructive care of public agencies.

CHANGES IN NURSING PROGRAMS IN BOTH TYPES OF AGENCY FROM 1932 TO 1933

The percentage distribution of visits

PERCENTAGE DISTRIBUTION BY TYPE OF VISITS TO CASES AND OF CASES UNDER CARE FOR PUBLIC AND PRIVATE AGENCIES, 1932 AND 1933



Based on reports by 18 public agencies in 13 urban areas and 38 private agencies in 26 urban areas

and of cases by type of service and the average number of visits per case for the three types of service indicate certain changes from 1932 to 1933 in the nursing programs of both public and private agencies. These variations are also shown by the percentage change from 1932 to 1933 in the number of visits to cases and the number of cases under care.

In *public agencies* there was a slight increase in the number of visits in the health supervision service from 1932 to 1933 with a large decrease in the number of cases under care in this service. This, as would be expected, produced an increase in the average number of visits per case, indicating a more intensive service for a fewer number of cases under care. In the morbidity service, there was a large decrease from 1932 to 1933 in the number of visits made and a much smaller decrease in the number of cases under care, with a consequent decrease in the average number of visits per case, indicating a less intensive service for morbidity cases. Both the number of visits made and the cases under care in the maternity service decreased in 1933; the greater decrease occurred in the number of cases, and as a result there was a slight increase in the average number of visits per case.

In *private agencies* the number of visits made and the number of cases under care (as well as the average number of visits per case) decreased in 1933 in all three services. In the health supervision service there was a large decrease in the number of visits and a very slight decrease in the number of cases under care, with a large decrease in the average number of visits per case. This indicates a less intensive health supervision service in 1933 by private agencies. In both the morbidity and the maternity services the decrease in the number of visits was greater than the decrease in the number of cases under care. In both services, therefore, the average number of visits per case decreased.

The figures available from these public and private agencies engaged in public health nursing indicate that in public agencies in 1933 more emphasis was given to the health supervision of infants and children of preschool age and to prenatal cases than was given to morbidity cases. Private agencies found it necessary in 1933 to do less intensive work for all types of service than in 1932, but the greatest reduction was in the health supervision service and the smallest in the morbidity service.

A SUNSHINE CAGE

Ingenious foolproof cages for babies are being used by the Chelsea (England) Babies' Club. The cages are hung outside the window to allow the baby to get the air and sunshine. Steel fencing, attached to steel rods, is used for the three sides and top; the bottom is made of a piece of mattress spring, attached to the rods, so that it will be flexible and comfortable for the child to lie on. The three sides, top, and bottom are fastened securely to each other and the whole cage is suspended outside the window on steel braces. There is no wire on the side of the cage nearest the window so that the baby can be put into and taken out of the cage by merely raising the window. A mat should be spread on the bottom of the cage so that the child has a soft padding underneath him. These cages have been passed by the Home Office.

A scheme has recently been proposed by the Royal Institute of British Architects whereby a small balcony for the baby will be built in every working- or middle-class flat.

—*The Nursing Times*, November 17, 1934, London, England.

Case-Finding and Case-Holding in Relation to Syphilis*

By RACHEL K. MILLER, R.N.
City Health Department Clinics, Berkeley, Cal.

ONE goal of every effective health department is the complete eradication of syphilis in the community which it serves. When conservative estimates place the percentage of syphilitics in the general population at about eight per cent, this goal seems difficult of attainment. Only thirty years ago, before the isolation of the causative organism, and the discovery of specific treatment, such a standard regarding syphilis would have seemed an idle dream. Today, we have definite guide posts pointing the way to ultimate attainment of this goal, however distant it may seem.

TREATMENT FACILITIES AT CLINICS

One of these guide posts is the establishment of adequate treatment facilities. The treatment of syphilis is prolonged and expensive and since the vast majority of our people are not financially able to pay the costs of medical treatment, it is obvious that if syphilis is to be eradicated, the Government must bear the financial burden.

There has been remarkable growth in the clinic method in the United States in the last thirty years. In 1900 there were probably less than 130 clinics in this country; today, there are not less than 7,000. Miss Margaret Plumley in her report entitled "Growth of Clinics in the United States" attributes this tremendous growth to the influence of organizations devoted to the prevention of all social diseases. Health departments of municipalities and counties have opened clinics of many types, the most frequent being for venereal diseases, tuberculosis and infant health. Sometimes the health officer provides the medical service and the quarters and calls upon the public health nursing association for nursing assistance. Now and then the clinic is housed by some private organization such as a settlement, and financed by the municipal health department.

Clinics for venereal diseases abound today, and yet either there are not enough of them or they are not properly administered, for the incidence of syphilis is not appreciably reduced. This presents a definite challenge to health departments, to formulate and administer improved programs. Case-finding methods should bring in a much larger percentage of early cases for diagnosis, and case-holding systems should keep these cases for treatment and observation until they have been symptom-free over a long period of time.

ESTABLISHING CONFIDENCE

An element of first importance is to eliminate fear and establish confidence. When people have faith and hope and know the source from which it comes, they besiege the giver and have neither to be sought nor held. The newly infected person who has been taught to recognize symptoms and can feel that treatment will be given without stigma, will be more liable to ask for treatment and come for it. Everyone who comes to the clinic is motivated by hope and many are not only ill but are dwarfed by wounded pride and thwarted ambition. Everyone who leaves the clinic should go out with confidence in its ability to help.

Dr. Michael M. Davis in his book,

*Presented at the joint session of the American Social Hygiene Association and Public Health Nursing Section of the American Public Health Association, Pasadena, Cal., September 3, 1934, and printed simultaneously in the *American Journal of Public Health and the Nation's Health*.

"Clinics, Hospitals, and Health Centers," makes the following statement: "The most important element in effective case control is the work done *while the patient is in the clinic,* not the correspondence or even the home visits which come afterward. Good service to the patient in the clinic, particularly at the first visit, is the most important single factor."

THE NURSE'S RESPONSIBILITY

The public health nurse has a unique part to play in making a clinic a success. Hoping for results in a syphilis control program, she has equipped herself with an understanding of the disease, its etiology, the modes of transmission, the usual methods of diagnosis and treatment, and the common reactions. She has also cultivated a sensitiveness to individual needs, especially in relation to mental and social complexities and twisted attitudes. Moreover, she has acquainted herself with the social welfare agencies of the community and has some idea of where to turn for assistance in making suitable adjustments that will enable the patient to continue treatment or to protect others. The possession of such qualities enables the public health nurse to perform a superb service as a go-between for clinic and home; physician and patient; patient and family, friends, and employer. Thus equipped she is far too valuable to devote her entire time to determining eligibility for clinic service or to routine clerical assistance of such proportions that no time is left for the very important social and educational measures which should be a part of every clinic.

Within the clinic the nurse makes a contribution to case control by the manner in which she receives patients. The ability to put herself in the patient's place and treat him as she herself would wish to be treated under similar circumstances, is her most valuable asset. She is interested in the patient as a human being, not as "Case number 768." When she approaches the printed forms intelligently and not in the manner of saying, "Just another case" she wins the confidence of the patient. One clinic reports that the giving of false addresses and delinquency in returning for treatment are rare. Another finds just the opposite to be true. Is this not due to the manner in which patients are treated? No individual relishes indifference or haughtiness. It matters greatly to the patient whether he is received by a disinterested registrar who routinely follows a list of questions, or whether he is met by a personality sensitive to his problems. The nurse who can, through carefully directed conversation, obtain all the pertinent facts without direct questioning and without antagonizing and arousing negative reactions, performs an effective part in case control.

HISTORY-TAKING

Careful history-taking is another important contribution which the nurse makes to case control. If a nurse's records contain such phrases as "history of contacts not significant" or if the nurse permits herself to be so dull as not to find one hint of the source of the patient's disease, it is no wonder she is sometimes relegated to less important services such as "pulling" histories and making out appointment slips. Many clinics, however, have learned the economy of correct history-taking by a careful nurse. It is an indispensable aid in the discovery of possible cases, and in dealing with cases where special adaptations are indicated. For example, while taking a history one day, the nurse observed that the patient fidgeted considerably and that her eyes turned repeatedly toward the clock. She immediately guessed the patient was in a hurry and in response to one sympathetic comment she learned that the woman had left a sick baby at home, that her husband was taking care of it but had to be at work at a given hour which was fast approaching and that the woman had already waited her turn for two hours. The nurse then handled the situation so that an exception was made to the usual routine and the woman was

seen by the physician and returned home to relieve her husband in time for his employment. The nurse noted on the record "family responsibilities," which would indicate to any of the clinic personnel that special adaptation of clinic routine was required.

Patients appreciate individual treatment and when it is received there is seldom any call for coercion. Necessity for coercion should be considered a frank acknowledgment of failure on the part of clinic personnel. The patient has not understood or has not been understood.

THE NURSE AS AN INTERPRETER

The usual function of the nurse as interpreter to the patient of the specialist's findings renders her of the utmost value in case control. Every patient will respond to a clear explanation of his particular case and with more enthusiastic coöperation. The nurse realizes that no two cases are ever exactly alike and recognizes the need, as interpreter, to connect the physician's findings to facts in the patient's own environment that his interests and attitudes may be sufficiently stirred to motivate coöperation.

Every person with syphilis who has been successfully treated should be urged to become a teacher in the campaign for prevention and cure of the disease. In some clinics a nurse regularly conducts a lecture to a waiting group. This would appear to be a valuable method of case-holding. Patients who think they are cured after a few injections, or after one negative Wassermann, or when they feel "perfectly well" ordinarily become delinquent. By clarifying and explaining why these are not good reasons for discontinuing treatment the nurse holds many of these cases without lapses. The lecture period makes clearer to patients the urgency of reporting promptly anything which is troubling them in relation to treatment, a painful injection, an unexpected reaction or any social circumstances which make clinic attendance difficult. The nurse tries to excite an emotional reaction against the present state of affairs and a hope of something better. She presents a truthful picture of the tragic effects of untreated syphilis and tries to inspire each patient with a sense of responsibility, not only to himself, but to his family and to the community who have to bear the suffering of congenital syphilis or the miserable effects of late lues. She also explains, in simple language, the ways in which syphilis is transmitted, the necessary concurrent disinfection and the hygienic measures the patient should adopt to protect others and urgently explains the necessity of immediate observation and careful examination of all contacts.

The nurse often makes herself valuable as an educator in other ways within the clinic. She endeavors to guide all the patient's experiences within the clinic so that they may favorably influence "his habits, his attitudes and knowledge" in relation to the prevention of syphilis. She tries to have the waiting and examining rooms arranged and managed in accordance with hygienic rules. She tries to do away with unnecessary massing of patients in one crowded waiting room for long hours of waiting. She takes an interest in the decoration of walls and the supply of pamphlets and pictures of an educational nature.

An elderly patient who had just been employed, after two years without any job, came to a clinic one day at noon, hoping to have an early chance for treatment. A large group was already waiting. The old gentleman waited until it was almost two o'clock and then when he explained to an attendant that his new job demanded that he be on duty at three o'clock, the attendant snapped, "Have to wait your turn," and a few weeks later the public health nurse had to hunt up another delinquent. As one discordant instrument in the orchestra ruins the symphony, so one member of the clinic staff who is not in harmony with the ideals of individualization for case-holding spoils the work already done by others.

Most clinics waste too much of the

patient's time. Various adaptations of the appointment system have largely overcome the long periods of waiting. Still, when carfare and absence from work require deprivations of a sort, clinic appointments should be carefully gauged. The nurse has an important part to play in emphasizing courtesy and individualization of the patient.

THE FOLLOW-UP SYSTEM

Well regulated clinics find some sort of efficient follow-up system indispensable not only for case-holding but for case-finding among contacts of a syphilitic patient. Here again, the public health nurse functions. She visits homes, and, with understanding and tact, makes an approach which leads patients, new and old, to the clinic doors. If the nurse serves periodically within the clinic in close coöperation with the physician, she finds her familiarity with present-day procedures a distinct advantage outside the clinic. It makes her more adept in case-finding and in handling the perplexities of patients especially in relation to misunderstood instructions. She helps to make social adjustments. Frequently she is called upon to clarify a patient's position in relation to his employer. She thus wins the patient's gratitude and renewed will to coöperate by helping him to hold a job from which an employer, untutored in the communicability of the disease, had unwisely expected to "fire" him.

The public health nurse, in the field, seeks to stimulate interest in routine Wassermann's on all prenatal cases; supervises the new-born babes of syphilitic women; she realizes that public information regarding syphilis is woefully lacking and tries to develop a sane, unemotional attitude toward it. Some years ago families tried to hide tuberculosis if it existed in their midst and thereby failed to take proper measures for its control for fear of an imagined stigma. What marvelous progress in change of attitude was indicated when several years ago, the newspapers of the country broadcast that a son of the President of the United States was found to be a victim of early tuberculosis and was to receive prompt treatment in a mountain rest home! Such publicity might never be desirable in relation to luetic infection, but surely it is obvious that a change of attitude toward it must continue.

It has been estimated that about ten per cent of syphilitics contact their infection in an innocent way. It is well also to recall the words of Dr. John Stokes, who writes that "no genealogic tree is so pure that syphilis has not twined itself among its branches." The nurse who carries into the homes a calm, scientific attitude toward this disease helps to bring about the revelation of many new cases.

Every found case, carefully studied for the identification of intimate contacts, is a means of prevention and eradication of the disease. The follow-up depends for its success upon a tactful, thoughtful method of approach. In this connection Dr. Nels A. Nelson writes forcibly as follows:

> "The search for 'sources of infection' requires understanding. It is unfortunate that the term 'source of infection' ever came into use in this connection. It is the most antagonistic approach that could possibly be made. A person who is accused of having infected another is quite naturally on the defensive. It is a perfectly understandable reaction. It is often an unjust accusation. The patient, on being questioned as to his exposure, naturally thinks of the last one. The incubation period is long enough and variable enough so that his contacts during that period may have been many. The last partner may have been exposed to his infection rather than have been the cause of it. Or the patient may have an acute recurrence of an old neglected infection which he mistakes for a new one. All of his recent contacts may then be victims of the patient's infection.
>
> "It is always safest to approach a contact, whether or not the alleged source of an infection, as the possible victim of an infection. Certainly every 'source of infection' must, at some time previously, have been the victim of another infection. The person thus approached is concerned in his or her own interest as the offended party. As there is no need for defense against accusation, the advice to seek medical attention is more readily accepted. It is better to think always in terms of case-finding than in the uncertain and often

unjust term of search for the 'source of infection.'"*

In conclusion: In spite of the large number of syphilis clinics in the United States there are very few localities where a well rounded piece of work is being carried on. There is need, in general, for less secrecy and a more scientific attitude toward this very prevalent disease, and, in particular, there should be greater individualization of cases. Each case is a potential teacher, each case a pivotal point for the location and eradication of many other cases.

Success of the most efficient medical treatment rests upon a well rounded supporting service in which every member of the staff shall be imbued with the ideal of complete eradication of syphilis that the ever-present danger in any institution of letting it degenerate into a machine shall be obviated. The Master has told us that "not a sparrow falleth" without the Creator's attention. When such is the spirit of the clinic its service to humanity in the eradication of human misery due to disease will have manifoldly increased.

*Nelson, Nels A. *Nurse in the Control of Gonorrhea and Syphilis.* PUBLIC HEALTH NURSING, April, 1933.

What the Social Worker Expects of the Nurse *

BY E. MARGUERITE GANE

Director, Department of Case Work, Children's Aid Society, Buffalo, N. Y.

THE social worker counts on getting immediate and highly skilled service for her clients from the community nurse whether she represents the schools, the visiting nurse association or the health department.

But the social worker asks of the nurse an even greater contribution in a non-medical field. I would like to confine myself to this one point.

There really is no such creature as a typical individual. But out of the mass of things that make up the daily routine of human beings, certain experiences stand out as common to all. For example: We observe typical reactions to the various crises of life—particularly the crises of birth, of illness, of death. The play of emotions surrounding these crises is much the same today under our highly developed civilization as it was among primitive tribes. Science has substituted a program of prenatal care for the old pregnancy taboos, black magic and superstitious quarantine of mothers. Skilled medical and nursing care have vanquished the "evil spirits" which produced the high mortality among savages as judged by the large number of skeletons of newly-born babies found in archæological excavations. Surgery, medication and hygiene have triumphed over the ancient devils which invariably turned sickness into death. But in spite of the control now exercised over these crucial experiences, they are even now identified with life's greatest emotional heights and depths.

Birth, illness, the threat of death charge the atmosphere with emotional waves—of joy, fear, pain, sorrow, insecurity, jealousy, resentment, great affection, sacrifice, or loyalty. Every phase of living is intensified; every word or act is of a significance which stands out in bold ruling as compared with the tone and color of everyday events.

By virtue of her profession the nurse enters the life of others at these critical periods to contribute her skill and

*Presented as a part of a symposium on Community Relationships and the Nurse, New York State Nurses' Association meeting, Buffalo, October 18, 1934.

service. Because she brings hope and security, emotions are laid bare. She may look into the deeper recesses of mind and soul that are ordinarily closed even to those who are nearest. *The use the nurse makes of these associations is of vital importance to the social worker.*

Her understanding of the significance of these emotional revelations may bring to the family a richer gift than physical health. Her lack of understanding may leave a scar on the family life. Let me illustrate:

The ninth child was born to a family receiving relief. This child was not wanted; was deeply resented by both parents. The mother turned away from it and refused to nurse it; the father was in despair.

The nurse exclaimed over the size and fine condition of the child. She displayed pride in him as the largest baby she had ever handled. She called every one's attention to this wonderful boy. In a few days all resentment had left the parents. They, too, began to show pride. They quoted the nurse.

Suppose this nurse, though she may have felt it, had agreed with the parents that the birth of this child was to be deplored? Any social worker who struggles with delinquent children and maladjusted adults knows how often their problems are traced directly to the reaction towards an unwanted child. This nurse might have strengthened the parents' rejection of this child and left behind her a baby starving for love, parents burdened with a sense of guilt towards the child and resentment towards life—a rolling snowball of a social problem.

The social worker wants the nurse to be as alert to the importance of family relationships or unusual attitudes, as she is to the changes in temperature and pulse.

By her very personality and intelligence the nurse treats the area outside of her medical province. She cannot avoid it. She enters a realm of highly sensitized emotions. She affects every family worker with whom she comes in contact—by her appearance, her manner, her speech. Often her very silence conveys meaning. Her faltering may incite fear. Her calmness brings new hope.

Because of these things the social worker believes the nurse is one of the greatest social forces in the community and her indispensable ally in developing the art of living.

More power to her!

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR FEBRUARY, 1935

Preservation of Human Milk*

By HAZEL M. KEENE

Assistant to General Director, The Directory for Mothers' Milk, Inc., Boston, Mass.

FLUCTUATIONS between the supply of and the demand for mothers' milk were so rapid and wide that the Directory for Mothers' Milk was faced with the problem of finding a method whereby the surplus supply, when available, could be preserved. On the Boston Floating Hospital in 1920 a method for preserving human milk was undertaken, and Dr. Paul W. Emerson, who as a member of the hospital staff had been interested in the process, was approached to assist us. The Floating Hospital executives were most receptive to the idea and gave permission to put their equipment in working order and set aside a room at their On-Shore Department for our use. A member of our Board paid the expenses of putting the equipment in order and another member by private solicitation secured funds for this first research study. A technician was employed, and under Dr. Emerson's supervision we tried the roller process in 1928. Collecting, pooling and pasteurizing the milk under our daily sterile routine, the surplus supply was sent in small refrigerator boxes for the study.

ROLLER PROCESS

The milk was permitted to flow onto the surface of one side of a heated revolving drum and in about ten seconds the dried product was scraped off by a knife blade from the opposite side. The drum was made of cast iron and heated from within by steam, under a pressure of 30 to 35 pounds. Dr. Emerson found after continued experimentation that human dried milk by the roller process was still lacking in some of the qualities that dried milk should have, and he approached the Borden Company Research Laboratories for advice. They suggested that the milk be sent to them at Syracuse, and they would set up a small dryer and try the spray process.

Accordingly, whenever a surplus of milk occurred here in Boston we would wire The Borden Company and they would arrange the time for the milk study after arrival of our shipment. A surplus of five quarts of mothers' milk is quite an item, but seems small to a large dairy company that is accustomed to handling gallons of cows' milk! Although the product obtained was an excellent one, they wished to study the process in the vicinity where the milk was collected, in order to avoid changes, such as the breaking up of the emulsion of fat (which is readily caused by slight shaking) incident to the transportation of the milk from Boston to Syracuse. Dr. Helge Schibstead was sent to Boston in February, 1932, and machinery set up in our laboratory.

SPRAYING PROCESS

The milk was forced through a needle valve in the form of a fine spray into a heated chamber arranged with a blower for the carrying over of the dried powder into a second chamber where it was collected. Seven hundred and twelve ounces were dried at our laboratory.

While Dr. Schibstead was here he demonstrated the possibility of the freezing process. The idea of freezing human milk occurred to Mr. Washington Platt of the Borden Research Laboratories in June, 1930, but its study was not undertaken until August of that year. It soon became apparent that the freezing process was more rapid, the apparatus much cheaper, requiring small space to operate and was easily sterilized. The product was perfect in appearance, and the process much superior to drying as applied to human milk.

*Continuation of the article on Maternal Milk Collection published in our December (1934) number.

FREEZING PROCESS NOW IN USE

On the flat surface of a block of dry ice measuring 10x10x2½ inches is placed a rectangular plate of aluminum 4x9x¼ inches, provided with six circular, shallow depressions with gradually sloping circumferences, each holding one-third of an ounce. When the metal is first put in position, it vibrates violently for a short time until it is reduced in temperature to that of the dry ice, about —80° C. The depressions are now filled with milk by means of a small pipette (30 c.c.). Another aluminum plate, without depressions and provided with a handle, is placed over the milk, and on top of this a cube of dry ice (10x10x2½ in.) (Fig. 1.) In about two minutes a clicking noise is heard which indicates that the milk has been frozen and has separated from the metal. It is now easy to flip out the wafers of frozen milk, which look precisely like peppermint candy, with the aid of a teaspoon, the bowl of which has been slightly flattened at the tip to permit its insertion between the wafers and the metal. The wafers may be transferred by two spoons to a common sterile preserving jar, which is capped, placed in a tight cardboard box provided with dry ice, and sent to the holding room of the Hood Ice Cream Company, to whom we take this opportunity of expressing our thanks. The temperature of this room is about 25°F. below zero.

Dr. Walter H. Eddy completed the vitamin study and the feeding case studies were done at the Boston Lying-In and the Children's Hospital.

SLOW VERSUS QUICK FREEZING

There is a general impression that frozen milk is harmful and milk left outside too long in the winter after delivery has been alleged to cause intestinal disturbances in babies. Emphasis must be placed upon the fact that such freezing is slow. Human milk frozen by the quick process used by us, has been found to be innocuous. Subjected to chemical analysis, to bacteriologic ex-

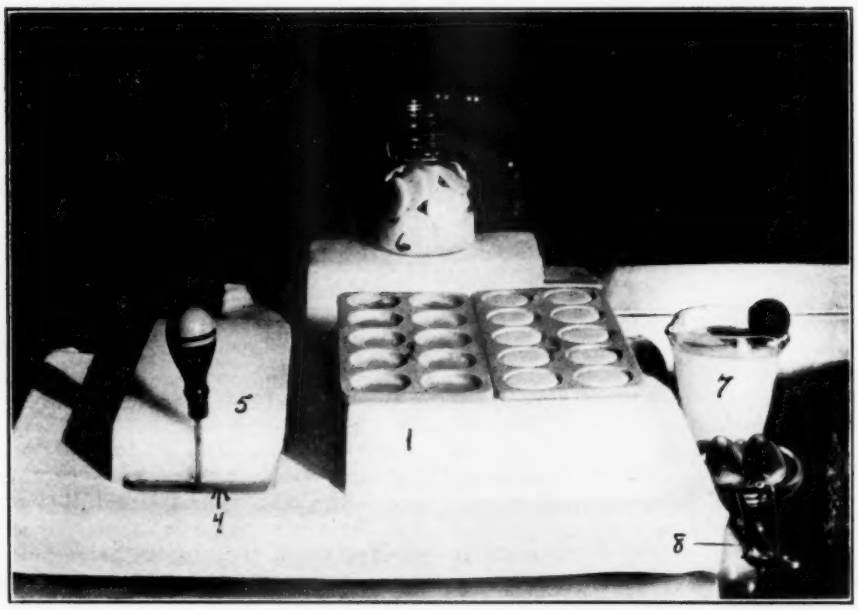


Fig. 1. Equipment for Freezing Human Milk

(1) Lower cube of dry ice; (2) lower aluminum plate, unfilled; (3) plate filled with wafers of frozen milk; (4) upper aluminum plate; (5) upper cube of dry ice; (6) preserving jar on dry ice, partly filled with wafers of frozen milk; (7) graduate with pipette filled with milk; (8) spoons for removing wafers, and top of jar.

amination, and to the test of being used as a food by babies, milk preserved by this method has been satisfactory. Milk frozen in February has been fed with success in July.

A total of 27,250 ounces were used studying the different processes from 1928 until 1933.

This past year 5,385½ ounces of frozen milk were used at intervals when a sudden increase occurred on orders, and at the close of the year we have 2,224 ounces in storage. The freezing of the milk enables us to hold our excess collection and be ready for any increase on orders.

At the present time we are shipping milk in the fresh state for some distance, but this new freezing process will mean that shipments can be made from Boston to considerable distances. We hope to find suitable refrigeration for holding the surplus supply at our own laboratory quarters.

A CHARM CAMPAIGN

A carefully thought out "charm campaign" has been used to interest Cleveland girls in good health, worked out by Virginia R. Wing, secretary of the Anti-Tuberculosis League. A portfolio "My Adventures in Charm" is issued to each girl who takes part. The girls enroll through clubs, organizations and schools and each group has a leader who receives a special bulletin each month suggesting additional ways of using the material supplied. Every detail of the plan appeals to the girl's desire to be good-looking. Nothing is said about health as such, only in its relation to attractiveness. The basis of the material is an account book in which the girl may check her beauty score.

—*News Bulletin*, Social Work Publicity Council, September, 1934.

THE RUDDY CRANBERRY

Aside from its esthetic values of eye and taste appeal, the cranberry is valuable in the diet chiefly for its high vitamin C, iodine, and energy values. The ash is slightly basic and contains significant amounts of potassium, phosphorus, manganese, and iron. The benzoic acid content of fresh cranberries varies from 0.035 to 0.095 per cent and quinic acid from 0.6 to 0.9 per cent.

Moderate, or even generous servings of cranberry sauce do not lower the blood alkali reserve but very large quantities decrease it significantly.

Fresh and frozen cranberries and whole-fruit jellied sauce are excellent sources of vitamin C and contain significant amounts of vitamin A as well. Vitamins B, D, and G are not present in significant amounts. The cranberry possesses considerable merit as a food and when eaten in normal quantities its wider use in the diet can be recommended.

—Nutritive Value of Cranberries, Carl R. Fellers, Ph.D., F.A.P.H. *Journal of Public Health and The Nation's Health*, January, 1933.

PUBLICITY FODDER

Winifred Humber, district public health nurse in the Ventura County Health Department, California, was successful in securing the following publicity notice in the local newspaper. This is a good example of how an unusual occurrence can be made to serve as publicity for your organization:

TWO MOTHERS PUSH BABY BUGGY FIVE MILES TO CLINIC TODAY

Trudging along five miles of dusty road and city pavement, two American mothers, each pushing a baby carriage, arrived at the baby clinic at the Community Center this morning, tired but happy. They found that their offsprings were healthy, so started back over the long trek homeward.

Twenty-three babies were examined today at the clinic held under the direction of Dr. Hainsworth and Miss Winifred Humber, Oxnard health nurse.

Nurse-of-the-Month

ANNA A. SCHMIDT
New York

Canandaigua, Ontario County, New York, is my home town where my preliminary education was received and where I was graduated from the F. F. Thompson Memorial Hospital Training School for Nurses. Several years following graduation were confined to private duty nursing in and about Ontario County. In 1929 a four months' course in public health training and field work, was taken at Simmons College, Boston, Mass., followed by a four months' period as staff nurse at Fulton, N. Y. State Department of Health Teaching Center for Maternity, Infancy and Child Hygiene. In November 1929, an appointment was received from the Wyoming County Board of Supervisors as Public Health Nurse for that county.

Wyoming is a rural county in the western part of New York State. The countryside is hilly, cut by two deep valleys and is lovely from early spring to late fall. Winters are a bit severe. The main highways are in good condition but side roads are usually impassable through winter and early spring. The county comprises 16 towns and covers a territory of 601 square miles with a population of 28,500. The ancestry is mixed. The chief occupation is dairying and general farming. Silver Springs in Gainesville Town has a large salt mine, Perry village a knitting mill.

The public health nurse is appointed yearly by the County Board of Supervisors. The appointment is approved by the State Department of Health which supports one-half the budget, the other half is maintained by the county. The nurse is responsible to a committee composed of three members of the Board of Supervisors and three physicians from the County Medical Society with whom she meets monthly. A supervising nurse from the State Department of Health usually attends the meetings at which the report of the nurse is given and plans and problems are discussed.

In order to cover the territory as adequately as possible and to give each town the benefit of the service, the county has been zoned with the nurse spending a week of each month in each zone. There are four towns in each zone and I plan to spend at least one day in each town which has a health chairman to whom calls for the nurse may be given. Each zone has a center, as: Arcade, Attica, Castile and Warsaw. A generalized program is carried on, including maternity, infancy, pre-school, school, tuberculosis and contagion.

During the summer months one preschool children's consultation, conducted by a member of the County Medical Society is held in each town. The consultation is held in the afternoon, each child comes by appointment made with

the chairman of that town. An average of 12-15 children attend. The age group stressed is preschool. The recommendations for the correction of defects are urged, the parents being advised to take their child to the family physician or dentist. In about one month following, the nurse endeavors to visit the home to follow up on corrections. In cases of insufficient funds, the Red Cross, interested organizations, and the County Commissioner are contacted.

Wyoming County has a State and County Hospital. On financial investigation and recommendation of a town welfare officer, patients are hospitalized as county cases. Because of continued unemployment and low incomes, many tonsillectomies are referred as such. On one occasion our Eye, Ear, Nose and Throat Surgeon stated that too many children were referrred for tonsillectomy. On another talk with him he remarked that fewer mastoid operations had been done of late years because of early removal of infected tonsils.

In the winter of 1933-1934, the Red Cross sponsored dental work among school children in two towns. Three town welfare officers arranged for dental care among children in relief families. There is much need for dental care and satisfaction is felt for even the small amount done, since funds are so limited.

Each year in eight towns of the county a toxoid clinic is held, four clinics in the spring and four in the fall. In this way the entire county is covered from diphtheria prevention every two years. Health chairmen assist in canvassing, on clinic days and in transportation.

The New York State Department of Health chest clinic comes to the county twice a year, usually at an interval of six months. The clinics are conducted 3-4 days in Warsaw and one day in Perry. The nurse assists in the organization of the clinic and previous to its coming, interviews each physician in the county regarding attendance. Following the clinic, with the physician's permission, the nurse does home visiting regarding recommendations. In May 1934, a tuberculosis study was conducted by the Division of Tuberculosis, State Department of Health, in Attica High School. The high school, pupils of seventh and eighth grades, teachers and janitors were X-rayed. Skin tests were done on those children who presented the written consent of the parent; 212 tests were done of which 10 per cent reacted. Such a study was the first done in the history of public health in the county. It furnished comment and aroused curiosity on the part of the villagers.

Once a month, well infant and preschool children's conferences are held in Arcade, Attica, Castile and Warsaw. In Arcade, Attica and Warsaw the conferences are conducted by the nurse, the children are weighed, measured and inspected and the mothers interviewed individually regarding care and management. In Castile, the Health Officer, donating his services, conducts the conference assisted by the nurse.

Since December 1933, under the Temporary Relief Administration, the nursing service has been allowed four nurses. The plan is to give employment to nurses and to supply nursing care to the community. The nurses work under supervision of the County Public Health Nurse. Because of this additional service a more complete canvass has been made in preparation for toxoid clinics. The assistance of these nurses at clinics has eliminated to a great extent the necessity of voluntary assistance on the part of local nurses. Where bedside care has been given, it has been well accepted. Their assistance has supplied more frequent visits to the homes for health supervision.

With the thought in mind that one of our great objectives is to assist in disease prevention, there is great satisfaction in knowing that at the close of 1934, 50 per cent of our preschool population are immunized against diphtheria. This is an incentive to work for a still higher figure.

Public Health in Syria

My diary during my stay in Biskanta, a village near Mt. Sannin of the Lebanon

By YEGANNEH CHAROOZ

This delightful description of health teaching in the hills of Lebanon (Syria) was sent in to us by Miss Jeannette Snyder of the American University Hospital in Beirut. Miss Charooz, the author, is a Persian and a senior student in the school of nursing connected with the University. She is evidently using every opportunity to put into practice the principles of public health that she has learned during her training.

July 15:

I arrived this morning at 9 a.m. in Biskanta. To my great surprise I found the population very small in comparison to that of the previous summer, for this place has always been famous for its good water, climate, and situation. I made inquiries of the old milkman whose little cottage is in the center of the village and who with his little brain could give you all the information you wished to have. The poor old man lifted his sorrowful eyes to my question of "Why is the village so lonely this year?" and told me that there had been an epidemic of typhoid fever recently which swept all over the village, taking his eldest son, leaving the younger one still alive but in a desperate condition. I made my way through the cottage to see the poor child. He looked anemic and apparently had been hemorrhaging the last few days. I gave him the necessary care and decided to attend to him once every day until he became better. Meanwhile I saw the mother carrying a bedpan which was used by the child, in her hand, intending to throw the contents of it carelessly a few yards away from the cottage. I caught her hand and seized the opportunity to help these people at least to prevent the loss of the rest of the family and the community. They had no toilets in which to dispose of their wastes. In fact most of these villagers did not care very much about arranging toilet facilities for themselves when they put up new houses.

I made her dig the ground with a gardening tool and bury the contents of the pan in it, and cover it well with soil. You see they are poor people. They cannot afford to disinfect articles by means of chemicals. So that was the best way I could think of. I told her to wash her hands thoroughly whenever she came in contact with that child. She is a good hearted woman and takes suggestions with an appreciative attitude and when she gets benefit of them and finds out that they work well, she gossips of her success to her neighbors.

I told the milkman, too, that if he did not wish the people of the community to get infected he had better express the cows' milk in the cleanest manner possible in well washed cans and cover them well to keep out flies and dust, and tell his two friends who are also milkmen to do the same. I left their lodging with a peaceful mind.

July 18:

Today I went up the hill for a walk to the spring which supplies the whole village with water. The water certainly looks very clean and drinkable as it comes out directly from the rocks, but to cause typhoid in fifty per cent of the people it must have become infected some way in the course of its flow. As I was absorbed in nature and its beauty I caught sight of youngsters playing hide-and-seek among trees and as soon as they saw me they recognized me and the eldest of them took hold of my parasol and as she was dragging me

along insisted on my following her home to meet her elder sister and the little baby boy which God had given her a few days ago. Eager enough, I agreed to accompany her home. I saw a young woman lying in her confinement bed with a little baby wrapped tightly in swaddling clothes, closely held to her bosom and sucking continuously. She looked happy, but ignorant. The first thing I did was to take her temperature with my thermometer, which I always carry in my purse, to see that she had no fever. After I made sure of this I took the baby from her, undid the clothes, inspected the navel to see whether it was infected or not. In fact there was some infection, though not serious, I took some alcohol with cotton out of my first-aid box and cleaned the wound well, put the dressings on, and let the baby alone. It started to cry and the mother begged me to let her take it and nurse it but I prevented her, explaining to her the reasons, firstly, because baby forms a habit and will never let her go about the house and do her work as it gets older; secondly, it is not healthy; thirdly, baby must cry for a certain period in order that the lungs may expand. I longed to instruct her about the care of this newborn infant who will some day be a grown-up, healthy young man and make her proud of himself. I started to talk to her about minor things today. I have arranged to teach her something every day. She seemed to be quite pleased with my offer. I am glad that it is her first child and I won't have much difficulty in making her believe what I say—mothers who have had many children have their own personal ideas, that they had such and such experience with their previous baby, that they gave it a certain stuff which worked well, so they are going to do the same with the next one.

July 20:

I can't stay at home and do nothing. I prefer to go about, find people and get acquainted with them, as I did again today. This time I went down-hill where the poppies, daisies, and other wild flowers grow. I saw a group of children trying to catch butterflies and torturing them. An idea occurred to my

A public health nurse talking with village children. Note outdoor oven with flat cakes of dried manure used for fuel

mind. I greeted them and directly entered into childish and interesting conversation with them and at last brought them to the point of catching flies and killing them instead of damaging these pretty creatures. One of the smartest boys asked for the best and easiest way of perishing those cunning insects for they are so many in number that he couldn't kill them all even if he spent all the day on it, and it wouldn't be fair to kill flies all day long, and yet they troubled him so much when he was eating or sleeping. I was very glad to demonstrate one of the methods which I had learned when I was at the school of nursing and found it to be of great help. I had no equipment right there, so he offered to take me and the rest of the children to his house. I showed the trick of trapping flies and my trick worked well, for the next moment I saw every child trying to imprison flies and destroy them.

July 22:

This morning I spent on visiting the patients whom I had found here and there, and gave their people directions about their food, care of their body, mouth, etc.

July 23:

Today I went up the hill again, and met two women sitting at the spring and chattering while filling their jars and washing a few articles of clothes. As I came closer I observed that one of them was pregnant. I became very much interested and frankly enough proposed to take her up and teach her prenatal care. I started my first lecture immediately, for not only she but her friend too showed signs of interest to listen to what I had to say. Meanwhile I gave them a hint about washing clothes in the drinking water and made them see from all points of view that the spread of the fever was due to this kind of horrible mistake. After I had finished talking they almost ran homeward to tell the others about it and make them join our class the next day at the spring.

July 24:

Today five more women had come to the spring to listen to me. This time children too had followed their mothers to help them carry jars. As I was talking the children were hopping and dancing around. Suddenly one of them fell on a rock and hurt his foot. I was very near to where he lay so I picked him up, washed the blood and dirt off the wound while everybody was watching me curiously to see what I would do next. Then I took a clean handkerchief out of my purse and tied it firmly around the wounded foot and made him sit by my side for the rest of the hour.

These mountaineers are quite witty after all and pick up what you say and try to imitate what you do. I explained the purpose of this procedure simply so they could understand.

July 27:

There is an elementary school in this village which was organized in 1925 by a well known man born in this village but educated abroad. There were about one hundred pupils playing on the playground and having recreation in the fresh air. None of them was tidy and clean.

I met the principal and asked to attend the classes for part of the day. He took me all over and made me listen to the children between the ages of six to fourteen, of four different grades, recite. In a short time I observed many things. What I concluded was that on the whole they are well nourished, healthy-looking young mountaineers.

There were some defects among the children that I noticed. The boy who was reciting would put his hand behind his ears and ask the teacher to repeat the question. Another child next to him would wrinkle his face trying to strain his poor-sighted eyes to see the writing on the board. I discussed it with the principal and offered to go the next day and make a thorough inspection and see which ones were not fitted to attend school unless something was done for them, and promised also to go every day and instruct the children about regular life habits and hygiene rules in the simplest form that they are

capable of understanding for half an hour.

July 28:

I found seven girls and nine boys who had defects of one sort or another. We thought of sending for their parents and telling them about the condition of these innocent kids and see if they would or could contribute something to correct these abnormalities. If not we would send them to the University clinic as free cases with a recommendation letter.

August 1:

Today I was called up to see a woman in labor. As I went in I saw an elderly woman whom I guessed to be the midwife, as she sat next to the patient with an unpleasant look in her face. She flushed with anger as she saw me go in my white uniform and a sack in my hand. This family didn't know that I had taken the midwifery course since last October when I left them. They had simply come to take me over and see if I could help in giving them ideas for saving the poor woman who was suffering for three days. I tried to listen to the fetal heart beat, but I could hardly hear it. After examining her I found out that she had a contracted pelvis and I assured the midwife that none of us could help save this woman and her baby unless we referred her to an obstetrician. I hired a car immediately, put the woman and her husband in it, myself, too, since I decided that I should be present to give her exact history. After the doctor decided that an operation should be performed I went away, made my shopping and at about four o'clock came up to the mountains. An hour ago, at 9:30 p.m., the hospital manager telephoned us and gave us the good news that the operation was done, but the baby is in a serious condition. They hope, however, that baby, too, will live.

August 3:

I do public health nursing eight hours daily, one hour at the spring instructing a big group of women about prenatal care, one hour visiting my patients and giving those people nursing care, one hour at school, three hours in the fields, on the hills or in the lake nearby with children to teach them games and sports. In the afternoons I go to a few houses where I have delivered cases and show them the way of taking care of their babies and themselves.

I am planning to do more during the next few weeks.

A Syrian Ploughman

Dialogue-of-the-Day

TRENCH MOUTH OR VINCENT'S ANGINA

Public Health Nurse: I have been hearing a lot about you, Trench Mouth, and I don't like what I hear!

Vincent's Angina: I guess you don't! I am a painful infection of the mouth, making multiple sores, causing difficulty in eating, fever, general malaise, and an unpleasant odor and taste. I destroy tissue between the teeth when I attack, and cover it with a yellowish-white membrane, leaving untouched areas deep scarlet in color. The tongue is furred, swollen, and reddened. The gums bleed easily. If not treated, I can do permanent damage to the teeth and gums. I am very painful and I am on the increase in the United States!

Public Health Nurse: You are contagious! That's what concerns me most.

Vincent's Angina: Very contagious. Drinking cups, tableware, pipes, towels, napkins, kisses, these are some of my carriers. I thrive in mouths carelessly cared for and I like dirty eating places where they do not wash utensils in hot soapsuds and water. Where they have individual service—paper cups, napkins, etc., I don't make much headway. I make rapid progress among groups, such as students, employees, and armies, especially if the people happen to be in a rundown condition and neglectful of mouth hygiene. I can be either acute or chronic. Of course, once you get me, you have to give up smoking, you cannot eat very hot or rough foods, and you must seek expert dental care at once. You must follow the dentist's advice to the letter. If you are careless in attending to treatments, or do not go for care early enough, I can be very serious, even setting up fatal sequelæ, though usually I am satisfied with prolonging your discomfort and leaving your mouth and teeth permanently crippled. One of my attacks does not confer immunity. You see I am a serious disease, all-in-all!

Public Health Nurse: I know that and mean to fight you by

(1) Insisting wherever I go and whenever I can on individual toilet and eating articles, and sterilization of china, tableware, glasses, and napkins in public eating places
(2) Urging daily mouth hygiene among children and adults alike
(3) Teaching the value of a balanced diet with plenty of fresh fruits, vegetables, and milk
(4) Advising an immediate visit to the dentist for any soreness of the mouth or gums
(5) Absolutely strict isolation after your diagnosis is made.

Will you like that, Trench Mouth?

Vincent's Angina: If everyone followed those rules, it would be the death of me!

Public Health Nurse: Fine. That's what I want.

Material for this dialogue gathered from the following sources:

Vincent's Angina. M. T. Van Studdiford, M.D. Southern Medical Journal, Vol. 27, No. 4, April, 1934, p. 358.

Vincent's Infection: Etiology, Diagnosis, and Treatment. Arthur H. Merritt, D.D.S. Journal of Dental Research, Vol. XIII, No. 1, February, 1933.

When Your Mouth Hurts. Radio talk. J. D. Dowling, M.D. Station WAPI, Birmingham, Alabama, November 8, 1934.

INEXPENSIVE RESTRAINT CUFFS

Quart cylindrical cartons, such as ice cream containers, make excellent cuffs for correcting the thumb-sucking habit. Muslin covers into which the carton can be slipped, may be made and sewed to the sleeves of an old dress as a foundation. By cutting off the lower half of the dress and running a drawstring in the yoke part, the device is as simple to put on as a bib, and one guaranteed to stay in place.—*Parents' Magazine,* August, 1933.

State E.R.A. Activities in Public Health Nursing

The various state E.R.A. programs being carried on by public health nurses are of great interest to our readers in terms of what is actually being accomplished for the health of people and the potential opportunity of winning a permanent place for public health nursing in community life. "Every community its public health nurse" has seemed an over-optimistic slogan in the years gone by, earnestly as we have believed in it. Now, however, there seems to be a real chance to make the dream more nearly true.

This magazine has already printed reports on E.R.A. activities in New York, Utah, Indiana, and Georgia (and we expect more news from these states later). In this number we are reporting present situations in seven states and will continue to give our readers news of E.R.A. developments as fast as they are sent to the National Organization for Public Health Nursing.—*The Editors.*

CALIFORNIA

A brief review of the nursing program under the Civil Works Service Administration might be in order before going into the present program for nurses under the State Emergency Relief Administration.

The only state-wide project for nurses under CWS had its inception at the National Child Health Recovery Conference in Washington, D. C., on October 6, 1933, at the call of the Secretary of Labor. To put into effect the recommendations of this Conference the State Department of Public Health, Bureau of Child Hygiene, decided to make use of the existing organization—that was, the California White House Conference on Child Health and Protection committees, both State and County. As there was no Division of Public Health Nursing in the State Department of Public Health it was necessary to appoint a Nurse-Director.

After appointment of the Nursing Director, five district supervisors were selected and brought to headquarters for a period of one week for instructions in the general plan of the project, and to decide on the type of report which would give insight into child health needs and tabulations of results. This group was appointed during January, 1934. Public health nurses were selected wherever possible for county field work and were introduced to their counties by their supervisors. Nurses were assigned on the basis of local needs and in many instances upon application of the health officer. The program was started in full swing by February 1. All of the nurses were employed upon child health projects and either supplemented programs where extra help was needed or covered work that otherwise would not have been done.

When the program was developed, 60 nurses were employed in addition to the supervising group. The program included a general survey of malnourished children. This was carried on largely through the schools and included infants and preschool children. Immunization campaigns for diphtheria and smallpox, dental surveys, eye clinics, special tuberculosis testing and chest clinics, plans for summer camps for undernourished children, home hygiene classes, crippled children surveys, and some special studies were conducted during the time that the project was in force.

A few of the figures gleaned from the statistical reports will give an idea of the large number of children given the benefit of inspection and of relief, where needed:

Estimated number of children in the district under county nurses (exclusive of cities)	114,001
Children given nursing inspections	35,271
Children given medical examinations	20,538
Making the total number of children reached by the survey	55,809

Although the total number of defects found in this large group was not completely reported, those listed reached the number of 41,301, with a total correction of 4,016 (nine per cent)—an excellent result at the end of three months' work.

The total number of malnourished children discovered was 6,178—about twelve per cent. Individual reports of the field nurses indicate that most of these children were malnourished before the depression, coming either from homes of low financial standing, or due to physical handicaps creating malnourishment or to improper home hygiene. In general it may be stated that the children discovered as malnourished in California were not malnourished due to the depression.

This project was carried on in California a month longer than in other states, the CWS Director being very loath to discontinue the service.

Out of this project there was developed a state-wide project under the direction of the Chief of the Bureau of Child Hygiene, State Department of Public Health, with a staff of fifteen public health nurses. The purpose of this project was to develop, build, and coördinate women's and professional projects. More than half of these nurses were diverted from the original purpose to assist the Epidemiological Division of the State Department of Public Health in research work connected with an epidemic of poliomyelitis.

Now, at the end of six months, we find five of these nurses in administrative positions in the counties to which they were assigned—Directors of Women's Work, coördinators of professional and technical work, etc.

On December first there were 525 nurses employed on SERA projects within the State, as staff nurses in city, county, and State University hospitals, visiting nurse associations, supplementing the work of school nurses, in city and county health departments, in the Social Service departments of SERA as visitors, and in some instances assisting with the making out of budgets, etc.; on surveys dealing with the medical, nursing or dental professions; on nurse-visiting housekeeper projects, nurses being engaged as supervisors and bedside nurses.

The problems that one encounters in this work are many. The first and greatest probably is the lack of understanding of the purpose of the New Deal on the part of the professional group; fear of "State Medicine" on the part of physicians and dentists. Hence their reluctance to participate in any program that might lead to such a plan. The second great problem, as I see it, is that in order to qualify for work, a nurse has to be in actual want. The third problem is lack of preparation of nurses for work in demand: as administrators, supervisors, teachers, visiting nurses—even to do the work that they have been educated to perform: bedside nursing in the homes of the less fortunate.

We have not solved any of these problems, but we believe that we have carved at least a partial plan out of the chaos. Studies are being made of our nursing situation, to ascertain:

How many nurses are unemployed
How many nurses are unemployable
How many nurses can be diverted into activities other than nursing
How can nurses be given the necessary instruction or education with practical experience while in service

How can we fit our student nurses to meet situations as they arise, to face facts instead of going around them?

The work has been valuable, not only to the nurses but to the communities served. Many of the public health nurses that served on CWS have been given permanent work. Private duty nurses have learned that there is something in preventive or public health work. The horizon of the nurse has

been enlarged. We are beginning to work with people; becoming less individualistic. The morale of the nurses has been raised. We have seen groups of people, so much worse off than we are, carrying on with their "chins up."

The value of the work is inestimable. I personally have done nothing that I considered so worthwhile since I was a student nurse in my school of nursing. To be even a small cog in this great big social revolution is a privilege that is accorded one only once in a lifetime—if then!

MARY E. DAVIS, R.N.
State Emergency Relief Administration, California.

KENTUCKY

Federal support for public health nursing is no new thing in Kentucky. In 1927, when floods devastated large areas in the eastern section of the State, administrative officials at Washington were quick to realize the emergency so created, and Congress was prompt in voting appropriations of Federal funds to protect public health throughout the affected regions. A similar policy was pursued in 1929 and 1930, when large sections of the State were visited by severe drought.

These emergency appropriations were handled through the United States Public Health Service, which allocated to the State Department of Health funds to be expended under the supervision of the Service and in accordance with plans approved by it. The wisdom of selecting the official State agency, with machinery already set up and, so, prepared to function with minimum delay, as the means through which to operate, was conclusively demonstrated by results. From July, 1927, to June 30, 1932, some three score county health departments, employing approximately 100 public health nurses, were organized through this Federal assistance. The splendid service established as an emergency measure was continued from July 1, 1932, to December 1, 1933, through special assignment of funds from Federal grants to Kentucky for emergency relief work.

On December 1, 1933, however, a change, for some reason difficult to understand, was made in the Federal policy in this regard. All funds for support of public health activities were discontinued, with the resultant release of 60 public health nurses attached to 55 county health departments. A few of these nurses were taken on as home visitors for relief work in their respective counties, but in no case were they even so much as considered for a nursing project, though such projects under CWA were proposed by local relief agencies in practically every county in the State. These nursing services were reinstated August 1, 1934, through funds provided by the State.

An Advisory Committee on Nursing was formed in October, 1933, as provided for in FERA Rulings Number 7. This Committee was sponsored by the State Organization for Public Health Nursing and financed by the Kentucky State Association of Registered Nurses. Representative of the State as a whole, it spent considerable time in formulating rules and regulations for the guidance of the Relief Administration in promoting nursing projects in Kentucky.

The Nursing Committee worked hard to secure the adoption of projects similar to those known to be in operation in other states, but the Federal Relief Administration in Kentucky persisted in turning a deaf ear. Three projects, however, were finally secured. One of these was at the City Hospital in Louisville, which gave employment to 102 nurses under CWS. Of these 102, three did visiting nursing under the Public Health Nursing Association. The second project was at the Waverly Hills Tuberculosis Hospital, to which 13 nurses were assigned. Of these 13, eight were used by the Tuberculosis Dispensary. The third was in connection with the U. S. Marine Hospital, where three

nurses were employed. Outside of Louisville, according to the reports of the Relief Administration, there were approximately twelve additional projects, giving employment to an aggregate of about nineteen nurses. With these projects, however, the Nursing Committee had nothing to do, except to verify registration of applicants. It is assumed that the nurses employed under them were assigned to private duty. Nurses on projects were allowed approximately thirty hours a week and paid sixty-five cents an hour. The Louisville projects were in force almost three months.

The Social Service Department of the Municipal Relief Bureau, through which the nursing projects in Louisville were developed, was very coöperative in interpreting relief needs of nurses. Members of the nursing committee were recognized as volunteer home visitors and their recommendations accepted without further investigation.

It is unfortunate that in a State where relief work was entirely under the control of the Federal authorities, nursing projects were so inadequately and so unintelligently developed. I believe that if such projects had been planned and executed through the regular, orderly channels of the United States Public Health Service or the Children's Bureau at Washington, we would not only have more adequately met the needs of unemployment, but have also built up a worthwhile service, instead of tearing down, partly at least, what had already been built. This opinion, from what I can learn, is shared by practically every nursing organization and every individual nurse in the State, with the possible exception of those directly benefitted by the few projects which were temporarily put into effect. Because of this situation, there is little or no enthusiasm in Kentucky for nursing under Federal Relief Administration.

Since the above was written, I am very happy to be able to add that the United States Public Health Service has been put in position to assist in restoring suspended public health nursing services. In addition, 26 public health nurses have already been added to organized health departments; others will follow. This corroborates what I have stated above—that organized agencies are the media through which public health nursing, whether emergency or permanent best functions.

MARGARET L. EAST,
Director, Bureau of Public Health Nursing.

MAINE

From January to June, 1934, we had 28 ERA nurses working on the Child Health Recovery program. They were working in all but two of the sixteen counties, locating and helping to secure physical examination of malnourished children on or eligible for relief. When the project was renewed in June, the number employed was reduced to 14. After the examinations were completed, the nurses made follow-up visits to interpret the findings to the parents and to secure as far as possible the recommendations made for each child, whether adequate diet, medical or surgical treatment. When they had secured all the care possible, we put these nurses on prenatal, infant and preschool work in the isolated parts of the counties in which they were working.

We have given the nurses as careful supervision as we could and have held monthly institutes with them since they have been doing the maternity and infancy work.

I confidently feel that the work these ERA nurses have been and still are doing has been of great value to the people with whom they have worked.

I would like to quote from a letter received today from my supervisor in which she reported her visit with one of the nurses who has been working in a small rural town: "I have never seen such reception in any town before. Almost without exception mothers

greeted us with 'I'm so glad you came, I wanted to ask you so and so,' and always asked nurse to come again, and somehow it helps a lot when parents ask questions and seem so interested."

It is my sincere hope that this work will stimulate the towns to give more attention to their health needs and to consider increasing nursing service.

EDITH L. SOULE, R.N.
Division Director, Bureau of Health, State Department of Health and Welfare, Maine.

NEW HAMPSHIRE

In New Hampshire an earnest effort has been made by the State and County Relief agencies to safeguard health; probably because the Governor of New Hampshire is himself so conscious of the necessity for public health measures translated into terms of adequate food—including milk for children, facilities for preventive and corrective health measures, and hospitalization. We are also fortunate in having a widespread public health nursing service covering cities and townships. There are approximately one hundred and fifty-four public health nurses in New Hampshire taking part in all the various phases of public health nursing activity.

There has been no mass employment of graduate nurses in relief projects in New Hampshire and up to December 1, 1934, the State Relief agency has placed 47 nurses—30 of these in public health services and 17 in hospital services. The requirements were graduation from an accredited school, registration and residence in New Hampshire. For public health nurses the salary was $25 per week—no expense allowance. Seven of these 30 nurses were placed with the State Board of Education for school nursing services and were under the Supervisor of Health in the Public Schools, who is a registered nurse. Ten were with the Maternity and Child Hygiene Division of the State Board of Health, under the Director of the Public Health Nursing Division. Eight were with a city health department under supervision of State Nursing Supervisors, either education or health; one with the State Welfare Department, and four were placed with city district nursing organizations having nursing supervisors. In addition to this the State Relief Administration paid district nursing associations (on a fee basis) for the care of the sick on relief. The majority of the public health nurses were employed in the program for correction of defects among children which was made possible by a special grant of $40,000 from Federal funds. These nurses were placed in towns having no public health nursing service or in towns thinly covered. The nurses were taken from the Federal unemployment lists except those on the Child Recovery Program. These were employed on the basis of experience for the work.

In employing nurses the problems presented were as follows: difficulty in finding nurses prepared to do public health work; their lack of knowledge as to what constitutes good health and a health service, of existing laws for the protection of health, of organization work, and of the distinction between the social service which belongs in a public health program and organized welfare work.

Problems were solved by frequent conferences with supervisors on health education, records, home visiting, etc. All nurses were placed under the immediate guidance of regular staff nurses of the State or local private organizations. Transportation was cared for by working out each day's program so that two nurses traveled together, covering communities or districts but not working together.

My impression of this program is varied and probably confused. Reactions to the whole situation run the gamut from ideals to realities and from personalities to actual service. The result of their experience will be educational and beneficial to the nurses and will have broadened their vision as to nursing and community needs. Their

service to public health has been faithful and self-sacrificing.

Results of the two-year relief program in New Hampshire cannot be tabulated until after January 1, 1935, but available statistics show that we have had no increase in morbidity or mortality rates, and the report of the Child Recovery Program will show a surprising number of nose, throat, eye, ear, and dental defects corrected.

MARY D. DAVIS, R.N.,
Director, Division Maternity, Infancy and Child Hygiene, State Department of Health.

NEW YORK

(For previous reports on some of New York's projects, see PUBLIC HEALTH NURSING for July and August, 1933.)

Some interesting data from the TERA nurses (591 of them) in this State follow:

Ages: Range from 19-64; largest number from 23-26 years.

Preliminary Education: 47 per cent are high school graduates; 3 per cent had some college work.

Professional Education: Out of training for 3-38 years; largest number under 5 years.

Postgraduate courses taken by 51, or 9 per cent.

Amount of employment in the year preceding TERA service: Less than six months, 503; of these 357 had less than three months.

Reasons for unemployment (sometimes a combination):

Unavailability of work	476
Housewife or other responsibilities	99
Illness	47

Average number months on TERA: 8¼.

Duties to which assigned:

General public health	401
School	42
Dispensaries and clinics	36
Hospitals	25
Tuberculosis	23
Nutrition survey	18
Communicable disease	18
Records	8
Social hygiene	6
Camp	3
Preschool cardiac	1
Dental work	1
Swimming pool	1
Social service	1
Laboratory	1
Stockroom	1

Cost of Transportation, weekly: City, $1.78; rural district, $5.21; town, $4.41; village, $1.40; county, $5.60—Average, $2.95 per week.

Transportation paid by: Self, 236; public funds, 135; VNA, 25; industrial firms, 3; friends, 3.

Reaction to work:

Very enthusiastic	425
Liked it	138
No remarks	20
Did not like it	5

—*Chats*, New York State Department of Health.

OREGON

As yet we have only thirteen nurses on SERA in the entire State, ten of these being in Portland at the University of Oregon Medical School Clinic, and two at the County Hospital. Only one nurse has been employed in the State outside of Portland.

A Medical Relief Program* for Oregon has been sent out by the State Relief Committee to each county, giving briefly the policies governing the combined medical, dental, and nursing program. It is not planned that nurses will be assigned to particular communities to carry out the program, but rather that physicians attending relief cases may select whatever nurse they wish to assist them—remuneration for both physician and nurse to be on a fee basis.

As yet this program is not organized to any extent in the State. To date there is only one county in the State really actively carrying it out, and there it consists mostly of medical and dental service. Since there has been very little need for bedside nursing care, no nurses, except in the one county mentioned above, have been put on.

MARY P. BILLMEYER, R.N.,
State Advisory Nurse, Bureau of Public Health Nursing, State Board of Health.

*On file at the N.O.P.H.N.

VIRGINIA

The original state-wide public health nursing project, under the CWA, started on December 15, 1933. This project was delegated to the State Health Department, and placed under the direct supervision of the Bureau of Nursing. The director of the bureau approved all nurses employed on this project, as to their eligibility both from the point of need and professional qualifications. By February, 1934, the payroll for this project showed the following assignments:

Public health nurses (urban)	40
Public health nurses (rural)	75
Tuberculosis survey nurses (rural)	15
Supervisory nurses	2
Bacteriologists	3
Statistician	1
Visiting housekeepers	10
Clerks and stenographers	40
Dietitian	1

All public health nurses were placed in well organized nursing services under the direction of the regular nurse, and assisted her to carry on a more intensive program. About fifty per cent of these nurses had had a course in public health nursing, or experience on a staff under good supervision. These were alloted to help in all phases of the generalized county nursing program, but the others, without such training or experience, were employed to assist in clinics, making surveys, etc.

The tuberculosis nurses, graduates of state sanatoria, were assigned to counties without nursing services for intensive tuberculosis surveys. Clerks were assigned to nursing services without clerical help and some to the state offices.

One specially trained tuberculosis nurse was assigned to supervise the tuberculosis nurses, and the other supervising nurse was assigned to the forty nurses in urban centers. All rural public health nurses (VERA) are supervised by the regular state supervising nurses.

On May 22, 1934, a supplement to the above project was approved for a six months' period, though with quite a reduction in the personnel. This project called for:

Public health nurses (urban)	38
Public health nurses (rural)	50
Tuberculosis survey nurses (rural)	20
Supervisory nurses	2
Bacteriologists	3
Visiting housekeepers	6
Clerks	26

The same general plan was carried out as outlined for the original project except that all applicants had to be approved for "work relief" by Relief Administrators.

Again on November 23, 1934, the second supplement was approved for an additional six months, but again with a reduction in personnel. At present we have:

Public health nurses (urban)	27
Public health nurses (rural)	50
Tuberculosis survey nurses (rural)	20
Supervisory nurses	2
Bacteriologists	4
Clerks	17

It is really quite remarkable what these nurses have accomplished with the inadequate supervision they have had, due to lack of supervising personnel. However, we have held five series of one-day group meetings in six sections of the state for all nurses. Papers or reviews have been assigned to the VERA nurses as well as to the regular nurses. The VERA nurses have participated in the discussions, and have done much reading of magazine articles, books from the State Health Library, on school nursing, public health nursing, the N.O.P.H.N. *Manual of Public Health Nursing*, etc., as well as making a study of the State *Manual of Public Health Nursing*, which was prepared for them and all regular nurses. Several of the nurses are taking the course in public health nursing given in the night classes at the Extension School of the College of William and Mary.

We have not only been able to provide work for those greatly in need of

it through this project, but the VERA nurses have accomplished much in assisting the regular nurses in expanding their programs as well as in helping to make the communities more conscious of their great need for health work.

MARY I. MASTIN, R.N.,
Director, Bureau Public Health Nursing, State Department of Health.

? ? ? Question Box ? ? ?

ERA NURSING PROBLEMS

Naturally the N.O.P.H.N. has been busy answering questions from executives, supervisors and board members on all phases of ERA nursing projects. Some of the recent difficulties presented and the N.O.P.H.N.'s suggestions are given here:

QUESTION:

Should ERA nurses in a city visiting nurse association be assigned their own districts?

ANSWER:

Unless the ERA nurses meet staff nurse qualifications, have had past public health nursing experience and have proved their ability to carry a district alone, the N.O.P.H.N. would not consider this an advisable plan. Working as staff nurses' assistants, ERA nurses should in time be able to assume the responsibility of a district, but until the supervisor is convinced of this ability and the satisfactoriness of home contacts, such practice might hurt the organization's relations to the community.

QUESTION:

If there is a local agency carrying on visiting nursing, should not the ERA nurses be assigned to it?

ANSWER:

In all relief planning, both Federal and N.O.P.H.N. recommendations have urged that nurses engaged to care for the sick on relief on a visit basis be assigned to previously existing public health nursing agencies in preference to starting a new service or to being assigned to an agency where there is no qualified public health nurse supervisor. Whether the ERA nurses be assigned to agencies carrying bedside or preventive programs or both is a matter of local agreement. Naturally, if the major service of the ERA nurse is to be bedside nursing it is natural to assign her to the visiting nurse association if there is one. If on the other hand the ERA nurse is being used in the preventive program where her work might duplicate the work of the official health department, then the efficient plan would be to assign her there. In cases where more than one agency might take ERA nurses, it would seem desirable to hold a joint meeting and plan to dovetail programs as closely as possible and agree on a mutually economical plan of procedure, bearing in mind always the good of the community and the maintenance of standards of service and supervision.

QUESTION:

Should our ERA nurses wear uniforms? If so, should they be just like the regular staff nurses?

ANSWER:

If the staff to which the ERA nurses are assigned wear uniforms, the ERA nurses should wear them with some slight distinguishing difference—color, armband, or other evidence that they are not of the regular staff. The indoor uniform is not difficult to secure, but the winter uniform coat is a problem. One agency arranged to have the summer coats lined and interlined for winter use. Another was able to buy two coats from former staff nurses, still another bought coats for the ERA nurses which the ERA nurses are paying for on time.

QUESTION:

Are ERA nurses eligible to membership in the N.O.P.H.N.?

ANSWER:

Indeed they are! If they have graduated from schools of nursing connected with a general

hospital with a daily average of fifty beds and are registered in the state, they are eligible for full nurse membership. If not, they are eligible for associate nurse membership.

QUESTION:

Should the ERA nurses attend all staff meetings?

ANSWER:

We cannot think of any reason for not including ERA nurses in all staff activities.

QUESTION:

Our ERA nurses want to prepare themselves more adequately for the field of public health nursing. Shall we encourage them to do so?

ANSWER:

If their work gives evidence of ability in teaching, tact, poise, good judgment, genuine interest and accomplishment in the field, if they are eligible for N.O.P.H.N. nurse membership and are high school graduates (or willing to complete high school) then every encouragement should be given to secure adequate preparation in theory and practice for this field. The N.O.P.H.N. will gladly send the list of courses available and answer questions on preparation for the work.

ON OUR WAY TO A NEW N.O.P.H.N. MEMBERSHIP GOAL

A Message to Members

Every member of the N.O.P.H.N., layman and nurse alike, can well feel proud of the 1934 record of 7,124 individuals enrolled. To the N.O.P.H.N. this has meant the stimulation of a loyal constituency and a financial revenue equal to one-fourth of the total budget.

This loyalty and financial support have been more powerful factors than many of you realize in bringing the N.O.P.H.N. and public health nursing through the crisis of the depression.

We stand today at a new highway. Before us are increasing opportunities, urgent demands and pressing challenges throughout the nation. Public health nursing must find its place in the social order and we can help to meet these challenges IF

all 1934 members renew
each member gets a new member.

In 1934, 7,124 members enrolled. To date this year we have 42% of that number. We are on our way to make the 1934 record, but let's go beyond it for the need is great—both yours and ours—for the strength that can come only through united action.

SOPHIE C. NELSON, *Chairman*, N.O.P.H.N. Membership Committee.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, Inc.

Edited by KATHARINE TUCKER

THE COMMONWEALTH FUND AGAIN CONTRIBUTES TO PUBLIC HEALTH NURSING

We are delighted to announce that the Commonwealth Fund has just made a special grant of $10,000 for 1935 to the N.O.P.H.N. with reservations of $8,000 and $6,000 set aside for the two succeeding years to be converted into appropriations on the basis of the National Organization's achievement in broadening its basis of support and in living up to its field opportunities. This appropriation for 1935 is toward helping the N.O.P.H.N. to tide over its present financial emergency —and to make it more possible to answer the calls that come from public health nurses and public health nursing agencies all over the country.

The N.O.P.H.N. budget of $97,000 is the goal (reduced from previous years) set by the Finance and Executive Committees for 1935 as a minimum essential to meet the present need for a national service, judged by immediate opportunities and demands made upon the N.O.P.H.N. What service can be given, and the strength of the national program must depend upon our ability to reach this goal. This generous gift from the Fund can be taken both as a good omen and as an increased responsibility. It puts a greater obligation and necessity upon the N.O.P.H.N. to work toward reasonable financial safety through the increased support of agencies, members, and contributors.

In expressing our appreciation to the Commonwealth Fund, we also express it to those who by their loyal support convinced the Commonwealth Fund that "our constituency" is also prepared to meet this situation.

Dorothy Carter, one of the assistant directors of the N.O.P.H.N. and assistant editor of the magazine underwent a thyroid operation in January. She is making satisfactory progress but will be on sick leave for several weeks.

FOR RURAL COMMITTEES

The N.O.P.H.N. has prepared in addition to the loan folders of material for rural committees on organizing public health nursing services, an outline for studying public health nursing services in counties. Send for your copy and plan your year's program based on this analysis. The N.O.P.H.N. will be glad to advise any group on its findings.

The joint boards of the three national nursing organizations held their annual meetings in New York, January 21-24. In addition to the N.O.P.H.N. board meetings, which will be summarized at a later date, the following N.O.P.H.N. committees met: Finance Committee, Magazine Committee (a dinner meeting), Field Studies Committee, and an informal meeting of S.O.P.H.N. presidents attending board meetings; also the following committees on which the N.O.P.H.N. has representation: Committee on Florence Nightingale International Memorial Foundation, Committee on Nursing Information Bureau, Committee on the Curriculum, Committee on Library Facilities, Committee on Saunders Medal, and Committee on Ethical Standards.

BOARD MEMBERS PAGE

Edited by KATHARINE BIGGS MCKINNEY

There are three main lines of interest for board members in this number of the magazine: The general one concerning such wide public health problems as housing, immigration, and relief, pages 55, 58, 63, and 95; the more intimate one of student affiliation, medical relationships, and changes in program due to recent difficulties, pages 69, 67, 75; and finally, what might be termed the "human side of the news": Miss Gane's summary of the public health nurse's function in the home, page 83, the nurse-of-the-month, page 88, and a snapshot picture of public health nursing in Syria, page 90. The last has an almost biblical flavor. We hope every board member reads Organization Notes, page 104, News, page 112, and glances through Book Notes, page 109, just to keep up to date with events and new publications. We call special attention to the new N.O.P.H.N. material for rural committees mentioned on page 104 and in this column last month.

This is your page—won't you drop the editor (Loudonville Road, Albany, New York) a line telling her how you would like it used? Do you find it helpful or do you go right through the magazine anyway, taking this page as it comes? Would you like more problems discussed—if so, what ones? Would you like a brief classified list of publications and articles of special interest to board members each month? We, the N.O.P.H.N Board and Committee Members' Section, are free to use this page in whatever way will be helpful to us. Won't you send me your suggestions?

A RURAL COMMUNITY—CONVENIENCE CUPBOARD

Such a cupboard was observed in a sparsely settled community having no contact with either state, county, or town nursing service. Two physicians served this district—traveling in some cases over twenty miles, "in fair weather and foul."

The plan for having available simple but necessary articles for caring for the sick was developed after a distressing experience during a severe snowstorm, which blocked the highways for several days. The sickness, croup, was fatal to two children. The physician upon arrival explained that great relief and possibly the actual saving of life might have resulted, had equipment for simple treatment been available. Immediately a group of neighbors, with suggestions from the physician, procured a few supplies for neighborhood use. Among these were:

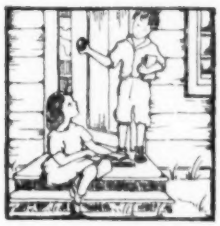
Mouth and rectal thermometers (two sets)
Enema equipment
Metal and rubber hot water bottles
Inhalation apparatus
Drinking tubes
Bed pans—large and small size
Old linen and muslin.

It would be highly desirable if this idea could be promoted in other rural districts which are without nursing service. Possibly this would be a plan to promote in the communities where we spend our summers.

A QUESTION AND ANSWER

Our nursing staff is giving an increasing amount of time to social case work problems, owing to the pressure on public relief workers, and the magnitude of the case load carried by private social agencies. Shall our nurses try to shoulder this additional burden?

Not if it can possibly be avoided. Case work and relief are not the public health nurse's primary responsibility and in an urban situation where specialized agencies are at hand it would seem well to refer the whole problem to these agencies. It is a suitable problem to bring before the Council of Social Agencies. It is well to have a clear understanding of the kinds of social service the public health nurse can assist in without undue infringement on her health and nursing program.

SCHOOL  HEALTH

MODERN ELSIE SERIES
MISS CARLING MIXES IN SOME MISCELLANEOUS QUESTIONS

During the last two months, quite a few questions from other school nurses have landed on Elsie Carling's desk. They have been on such scattered subjects that she has not been able to combine them in one series and instead is answering them this month, question by question, with the help of the N.O.P.H.N. The regular series will continue in March.

Miss Carling, do you wear a uniform and do you think it is a good plan?

Yes, I wear a uniform while on duty. I feel better prepared for my work, I am more easily recognized by children, teachers and parents and it saves my other clothes. I wear dark blue washable crepe de chine or dark blue chambray with white collars and cuffs. It is not a stiff or professional looking uniform, nothing "hospital-y" about it. I wear my school pin and wrist watch and these are the only pieces of jewelry. I wear gun metal colored stockings and moderate-heeled, black oxfords, a dark tailored hat and plain coat. I carry a school nurse's bag—a sort of glorified small brief case—when I make home visits. The N.O.P.H.N. Manuals recommend a uniform. Some nurses wear a washable smock or tailored, slip-on washable garment of some sort while in the school building. The important point is to look neat, professionally prepared for the job, and be easily recognized.

Miss Carling, I want to develop a health committee of the Parent-Teachers Association. How shall I do it?

Well, in the first place I'd be sure that the principal and the school doctor and some of the leading teachers interested in health liked the idea, and that the constitution of the P.T.A. allowed for the appointment of a health committee chairman. Then I'd draw up a list of things on which I needed help. Some of the things would be, transportation of children to and from distant clinics if parents cannot arrange it, transportation of sick children from school to home if no other means offer, help in arranging nurse's office and rest room, assistance in arranging for the preschool round-up, immunization campaigns, hot lunches, etc. Then I'd go to see the president of the P.T.A. and talk over with her the need and ask if the Health Committee can be of assistance and form an advisory committee to the nurse. I'd try to get her to suggest that the principal and a teacher or two and possibly a member of the school board be asked to serve on the committee and the local health officer in an advisory capacity. The school doctor and nurse would of course be *ex-officio* members of the committee. A Health Committee of 7 or 9 would be ample to start with. If the president agrees to the idea I'd ask for a meeting of the Health Committee at once and present my most pressing problem. While they worked on problems I'd try to get them interested in the health program as a whole and invite them to visit my office. I'd try to call on the committee as much as possible and share with it as many of the difficulties and triumphs of our work as I could. I'd try to see that the chairman held regular meetings, planned an agenda and program and showed each member how to be a good interpreter of our health work. The chairman would report back regularly to the P.T.A. I'd try to show the committee that only through concerted home action can children find satisfaction in observing some of the fundamental principles of wholesome living.

I am supposed to spend an hour every day at the High School as a part of my program. I find it hard to keep to a definite hour every day, and I do not feel the students come to me freely. What shall I do?

Of course it is difficult to expect much if your visits are irregular. I think I'd work on that first. Could you arrange three two-hour periods instead of five one-hour? Or two, two and one-half hour periods? Have those hours posted and announced and keep to the schedule. Can you keep a list of those using the rest room most frequently? It is a good way to discover students needing health advice. Do you talk with the physical educational director regularly and keep track of the members of athletic teams and interview all those returning after absence for illness? Have you tried informal little hygiene talks to groups of girls that may be planning to go into business—health as a business asset and how to groom for health? You may find a lot of the students have never had accurate hearing tests with the audiometer. You can always help the overweights and underweights with their problems. You will have to make the advances with this older group until they learn to turn to you.

In certain respects class advisors or homeroom teachers serve in the same capacity in the high school as does the elementary classroom teacher. Individual problems of pupils may be brought to the attention of these advisors. Therefore, the advisor's interest in health should be stimulated so that he will be on the alert to promote constructive working relationships between students and nurse. Through the principal, a typed or mimeographed outline of services which are available for high school students should be placed in the hands of each advisor. If the distribution of the outlines can take place at a group meeting and be preceded by a few explanatory remarks by both the principal and the nurse, so much the better.

A question box kept in physical education, hygiene, or home economics classes, in which those questions which can be satisfactorily discussed by the nurse are placed has proved helpful in developing working relationships between high school students and the nurse. A special time should be selected for the nurse's visit to the appropriate group for consideration of the questions.

Some nurses have gained a strong footho'd in the high school by attending a few athletic games, plays, or other social activities of the students.

I do not think the school authorities understand our health program. They think of the nurse as a convenience in first aid and some one to tell the children when to go home when they are sick, but the less we interfere with school routine the better. What can we do about this?

This is the same problem every public health nurse faces. The managers of industry think of the industrial nurse as a finger-wrapper, the expectant mother wants the nurse to give bedside care when the baby comes and not to bother her, during the prenatal period, the father of the sick child wants the nurse to give the enema ordered by the doctor and go away, but the tactful public health nurse gets around all these difficulties and shows how she can be useful as a teacher of health and preventer of disease as well as a first-aider. In the case of school nurses, working with a group who do not see the wider potentialities of the program, these suggestions may prove helpful:

(1) Discover the teachers most interested in health. Talk with them about your goals. Ask them to interpret your objectives to others whenever the chance offers.

(2) Ask to have the health committee of the P.T.A. serve in an advisory capacity for your program and explain your program to its members (see answer on page 106.)

(3) Make a point of rendering accurate, interesting reports to the authorities at regular intervals, including something each time relating to the broader aspects of your work. Add a "human interest" story once in a while.

(4) Talk in person with the authorities whenever you can. Tell them about what you are trying to do, as well as what you have done. Explain why you do things and relate what you do to the academic performance of pupils—not health for health's sake.

(5) See that reports of health committee activities reach the uncoöperative group.

(6) Outline at beginning of the year some of the things you hope to accomplish (and why) and show to principal and others. Post progress reports.

(7) Choose one outstanding difficulty in your work, for instance, the control of the common cold. Study last year's reports and see how many days of absence were lost as a result of colds. Outline a cold preventive program for your schools. Talk over with all the interested individuals first to add ideas. Then show to the authorities asking for their help and approval. The prospect of better attendance cannot fail to interest them. (Be sure to include teachers in your preventive co'd program.)

(8) Develop an appropriate health supervision program for the teachers (not diagnostic nor remedial but positive and preventive.)

Have you tried bringing authoritative literature, some from the National Education Association, or health programs to the attention of your school authorities?

The recent publication of the White House Conference on Chi d Health and Protection, "The School Health Program," defines the scope of health education and relates school nursing to the whole. Many school authorities are unaware of the existence of the publication of the National Education Association, "Health Education." While this is a course of study it is helpful in extending one's view of the health education program. Miss Chayer's "School Nursing" might be left with the principal or superintendent for review. "Safety and Health of the School Child—A Self-Survey of School Conditions," by J. F. Rogers, Federal Office of Education, is useful in discovering present status and continuing needs.

It is suggested that arrangements be made for teachers to visit other schools in which constructive health work is in operation. One also might discover which schools in the immediate vicinity have satisfactorily met the conditions which continue to constitute problems for you. These, if brought to the attention of the school authorities, might prove the needed incentive for attacking the problem in your particular situation.

FOR STAMMERERS

For the benefit of school teachers who have stammerers in their classes, the following directions have been prepared by Dr. F. L. Patry of the New York State Department of Education. They are equally useful for public health nurses.

1. Pronounce all words correctly and distinctly, since the student acquires speech through imitation.
2. Urge the child to think the sounds before attempting to make them.
3. Never correct the child's speech in the presence of his classmates.
4. Do not call on the student to recite, but encourage him to volunteer when he is ready.
5. Never miss an opportunity to praise and encourage the efforts of the student whose confidence has been destroyed by his speech defect.
6. Convince the child that he can overcome his defect.
7. Special exercises in relaxation and in correct pronunciation are very helpful.
8. Encourage the child to engage in the usual social and athletic activities of the school in order that he may not feel that he is different from other children.
9. Secure the coöperation of the parents in order that the child may have their encouragement and assistance in practicing at home the special exercises necessary to correct his speech.
10. The child should speak aloud during the home study period, as silent practice is of little value in overcoming a speech defect.
11. Writing out the first letter of each word in a sentence will assist the stutterer to overcome the tendency to repetition of the first letter or syllable.
12. If there is a tendency to ambidexterity make occasion to exercise the predominant right or left hand. Games of throwing and sport activities which utilize predominantly one arm or the other should be pushed.

—From *Mental Hygiene News*, June, 1933, published by New York State Department of Mental Hygiene.

EDITED BY
DOROTHY J. CARTER

KEEPING A SOUND MIND

By John J. B. Morgan. The Macmillan Company, New York, 1934. 440 p. $2.00.

This is a well presented mental hygiene text book suitable for college age men and women. It presents the following subjects: How to evaluate your mental health, mental conflicts, the mastery of fear, what to fight for, how to fight, emotional maturity, correct thinking, counteracting defects, exaggerating defects, crime, overcoming emotional depressions, how to get things done, getting along with people, and self-confidence. There are questions for class discussion in connection with each chapter and a selected list of references for further reading at the end of the book.

The book is valuable in itself, but its effectiveness will be enriched greatly if a well qualified instructor assists the student to apply its personal lessons.

ESSENTIALS OF PEDIATRICS FOR NURSES

By Philip C. Jeans, A.B., M.D., and Winifred Rand, R.N. J. B. Lippincott Company, Philadelphia. Price $3.00.

Dr. Jeans in his preface states: "In preparing this textbook care has been taken to include all of the subject matter suggested in the curriculum for schools of nursing prepared by the National League of Nursing Education. Though the book contains the essentials of the technics which are peculiarly concerned with pediatric nursing and emphasizes the care of the child in health and in illness, more emphasis than perhaps is customary has been given to discussion of phases other than the technics of nursing. Many of the subjects are discussed in considerable detail, considering the space limitations of a small textbook. This is done with a realization that nurses usually are eager to extend their knowledge beyond that which is expected of them. A nurse should not be called upon to diagnose the nature of an illness and prescribe for a patient, yet a knowledge of these fields is an aid in understanding the reasons for those things which she is required to do. Better and more intelligent work results when the reasons for the task are understood."

The results of this method are excellent. The text is profusely illustrated, and the two chapters contributed by Miss Rand on child guidance and nursing care are helpful in giving the nurse hints on managing children and their special problems. Throughout there is a nice balance between the picture of the normal child and the child who is ill, and it is a joy to find that the parents of sick children are not forgotten: for example, what to tell the parents of a feeble-minded child, the attitude of parents toward their diabetic child, etc. Summaries at the end of each chapter will aid the student. This is a good reference book for public health nurses.

—D.D.

BOY AND GIRL TRAMPS OF AMERICA

By Thomas Minehan. Farrar & Rinehart, N. Y., 1934. $2.50.

This book is a shocking and enlightening sidelight on the itinerant life of the thousands of boys and girls under twenty-one who have left or been turned out of poverty-stricken homes to travel the highways, living in hobo jungles and box cars, and confronting terrific hardships. Thomas Minehan, a young professor of sociology at the University of Minnesota, went out among these boys and girls for three years—living with them and studying them—and his book is an understanding and dramatic account of these boy and girl tramps—why they leave home; how they sleep, eat, and clothe themselves; their religious and sex life; their philosophy and standards. It is an appalling but accu-

rate study of this grave social problem, based on personal observation and fact.

PHYLLIS B. CALVIN.

NOTES ON NEW PUBLICATIONS

Some Notable Epidemics, by H. Harold Scott, M.D., F.R.C.P., D.P.H., Assistant Director, Bureau of Hygiene and Tropical Diseases, London, published by William Wood & Company, Baltimore, Maryland, $4.75. An interesting study of how to deal with epidemics, beginning with the cholera outbreak in London in 1854, and ending with dysentery cases in London in 1933.

Papers of Charles V. Chapin, M.D.—A Review of Public Health Realities. The Commonwealth Fund, New York, $1.50. A collection of sixteen of the many papers Dr. Chapin has written, selected as being representative of his valuable contributions to the field of public health. The papers have been grouped according to the health activities to which they are most applicable: public health administration; the control of communicable disease; epidemiology and vital statistics.

A new booklet, *What You Should Know About Tuberculosis—A Handbook for Tuberculosis Patients,* has recently been issued by the National Tuberculosis Association, 50 West 50th Street, New York. A very readable and interesting story of tuberculosis—its causes and cures—effectively presented in this encouraging and helpful booklet for tuberculosis patients; also to be used as a handbook of general information for everyone.

How Safe Is Home? If we judge by the statistics and records of home accidents compiled by Howard Whipple Green, Director of Statistics and Research of the Cleveland Health Council, home is apparently not the safe place we always thought it to be. In the introduction to *How Safe Is Home,* Mr. Green states the astonishing fact that "A total of 1094 men and women, boys and girls, and babies died in Greater Cleveland from fatal accidents right at home, during the five-and-a-half year period, January 1929 to June 1934. When this number is compared with the 1495 automobile accidents occurring in our streets during the same period, it may be concluded that perhaps it is nearly as safe to brave the buzzing highways as to stay peacefully at home."

In his study, Mr. Green has divided the causes of death in the home into two classifications—those caused by fatal illnesses, and those by fatal accidents—and these in turn are further broken down into kinds of illnesses and accidents. However, he places his emphasis on home accidents and his figures are quite amazing. Statistics for home accidents are given by age, sex, and economic groups (as are statistics for fatal illnesses), with many graphs, charts, tables, and maps giving the various numbers according to these classifications. Falls are the most important cause of accidental death in the home, with burns running a close second. Other important causes are asphyxiation, suffocation, poisoning, cuts and scratches, strangulation, gun wounds, automobile accidents at home, drowning, electrocution, and various others.

How Safe Is Home is a most interesting and laudable piece of propaganda for a program for the prevention of home accidents, and as a fitting conclusion Mr. Green says, "A large proportion of all fatal home accidents can be prevented. Education directed to the proper age-groups and geographical areas for the proper cause of fatal accidents, directed at the right season of the year should result in saving many lives and in preventing many accidents. To that end this work is dedicated." Cleveland Health Council. Fifty cents.

The National Congress of Parents and Teachers has recently issued a new book for laymen—*Our Public Schools*—written by men and women nationally known in the field of public education. *Our Public Schools* describes the history of the public schools, how they are organized, supported, and administered, and their place in the new social order. Copies may be obtained from the National Congress of Parents and Teachers, Washington, D. C., price fifty cents.

NEW EDITIONS

Two Revised Red Cross Manuals: "When Disaster Strikes"—Manual of Preparedness and Relief. This manual has been revised to include new procedures in disaster preparedness and relief administration in addition to the basic disaster relief policies as outlined in the old manual. In view of the fact that during the past ten years there has been an average of eighty disasters annually in this country, affecting each State in the Union, it behooves every community to be prepared to meet emergencies when they arise. Preparedness, if carried out along the lines set forth in "When Disaster Strikes", should go far in reducing the hardship and suffering caused by disasters. The manual tells what to do when disaster strikes—disaster relief policies, organization of committees on disaster preparedness and relief, fund-raising and public information, disaster relief procedure and financial procedure. A. R. C. 209, Revised October 1934—American National Red Cross, Washington, D. C. Free.

"Civilian Home Service"—A Discussion of Organization and Principles and Procedures Involved in Family Social Case Work as a Chapter Program. This pamphlet is to be used for instruction and guidance on the organization plan and policies of the Civilian Home Service. The discussion of case work is brief and limited since the booklet is more directly concerned with problems of organization. A. R. C. 288, Revised November 1934—American National Red Cross, Washington, D. C. Free.

The second edition of *Mental Hygiene and the Public Health Nurse* by V. May MacDonald, R.N., has recently been published by the J. B. Lippincott Company, Philadelphia. $1.00.

Out of Babyhood Into Childhood—1 to 6 Years—A pamphlet covering the diet, habits, and care of the child, published by the United States Department of Labor, Children's Bureau, Washington, D. C. This has recently been revised, and copies may be obtained from the Superintendent of Documents, Washington, D. C. for five cents.

Two excellent articles to suggest to Parent-Teacher groups and mothers of preschool children, giving some welcome and needed advice on contagious diseases, are found in the January issue of The National Parent-Teacher Magazine, Child Welfare: "Dodging Contagious Diseases," by W. W. Bauer, M.D., and "When Your Family Is In Quarantine" by Vera Stocker.

To School Nurses—President Roosevelt has inscribed a splendid photograph of himself—"To the pupils and teachers of the United States. Franklin D. Roosevelt." Copies of this inscribed photograph, 9 x 11 inches, on heavy paper suitable for framing, are available from the Superintendent of Documents, Government Printing Office, Washingington, D. C. 10 cents in check or money order.

FROM CURRENT PERIODICALS

Nursery Crimes. Bergen Evans. Atlantic Monthly, December, 1934.

The Robinson Family. S. J. Crumbine, M.D. National Parent-Teacher Magazine, Child Welfare (Washington, D. C.), December, 1934.

This Business of the School Lunch. C. C. Hart. Journal of Home Economics (Baltimore), December, 1934.

Better School Lunches—Massachusetts Surveys the Situation. Mary Spalding and Angeline Hamblen. Trained Nurse and Hospital Review. November, 1934.

The Relation of Nutrition to Health Problems of College Girls. Henrietta Fleck. The Medical Woman's Journal, December, 1934.

The Economic Depression and Mental Health. G. L. Hastings. International Nursing Review (Geneva), January-October, 1934.

The Private Life of the Rural Nurse. Jennie MacMaster, R.N. Trained Nurse and Hospital Review (New York), November, 1934.

Some Obesity "Cures" and "Treatments." Dr. Arthur J. Cramp. Hygeia, January, 1935.

Dental Defects and Mental Hygiene—A Radio Talk. Kermit F. Knudtzon, D.D.S. Mental Health Bulletin (Illinois Society for Mental Hygiene), October, 1934.

Selecting the municipality of Woodworth, with a population of 2,000, in Manitoba, Canada, as its laboratory, the Manitoba Department of Health contemplates a two-year practical test of a health insurance plan, which is slated to start in the spring. The plan provides:

1. Complete medical service, including surgery, hospitalization, and cost of prescriptions;
2. Payment of doctors' fees and hospital charges through taxation on property and a poll tax;
3. Right of the individual, within reasonable limits, to choose his own physician or surgeon, and select the hospital to which he desires to go for treatment;
4. Maintenance of competition between doctors, continuance of the high standard of medical care and protection against racketeering by doctors.

In cases where home treatment was preferred to hospitalization, allowance would be made for the services of a nurse. All maternity cases would be handled in homes except under circumstances which made removal to hospital necessary. Provision also would be made for preventive service, including medical examination of school children, vaccination and immunization against diphtheria.

Result of the experiment will be the guide to the government in extending the service, eventually slated to cover the whole province.

✣

The Greater New York Safety Council is planning to hold its sixth annual conference March 5-7 at the Pennsylvania Hotel, New York City. The Conference is sponsored by sixty national and local groups and it is expected that four thousand delegates from the Eastern States will attend. The section of the program committee concerned with home safety will hold a session, the general subject being "Home Safety and the Child."

The Health Section of the World Federation of Education Associations is arranging a European travel and study tour in connection with the Federation meeting at Oxford, England, August 10-17. Leaving New York June 29, the tour will visit France, Switzerland, Germany, Poland, Russia, Finland, Sweden, Denmark and England. The group will meet the leaders in school health in each of these countries. For further information, write to the Chairman of the Health Section, Professor C. E. Turner, Massachusetts Institute of Technology, Cambridge, Mass.

✣

The twelfth annual meeting of the American Orthopsychiatric Association will be held at the Pennsylvania Hotel in New York City, February 21-23.

✣

The International Hospital Association announces that the Fourth International Hospital Congress will be held in Rome, May 5-12. The Italian Government is making the necessary arrangements in collaboration with the chairman of the I.H.A.

✣

Martha M. Eliot, M.D., is back in Washington, D. C., to stay, as Assistant Chief in the U. S. Children's Bureau.

✣

Miss Christiane Reimann, former secretary of the International Council of Nurses, was married in August to Dr. Wilhelm F. C. Alter of Germany, editor of *Nosokomeion*, the official organ of the International Hospital Association. Mrs. Alter is making her home in Siracusa, Sicily.

✣

Word has just reached us that Dr. Dafoe, the doctor in attendance on the world-famous quintuplets, is the husband of a Henry Street nurse. As one young nurse exclaimed: That explains a lot!

One of the major school projects of New York City's relief administration is the provision of free lunches for under-nourished children. In a typical month, 1,164,898 lunches were served to about 80,000 school children a day. These free lunches are served in some 450 schools and in a few settlement houses. The cost of school lunches for this typical month was $57,994 exclusive of milk, which cost $27,101, bringing the total expenditure to $85,095. A staff of workers stationed in a central Terminal Market includes 86 chauffeurs, 92 handymen, and 40 lunchroom helpers, as well as a clerical staff and a staff of investigators. The central kitchens and lunch-rooms have the daily supervision of nine home-making teachers, from the Department of Education, each a trained dietitian. The Emergency Relief Bureau supplies 790 workers in the lunchrooms, and 197 in the central kitchens. The entire staff required to prepare, serve and supervise the provision of these daily lunches to 80,000 children includes 1,469 men and women relief workers.

✣

Community Chests and Councils, Inc., states that 187 chests reported that they raised $39,618,912 this past year, practically the same amount as in 1933. While contributions decreased from 1929-34, the decrease was checked this year.

✣

The California S.O.P.H.N. at its annual meeting appointed a Committee on Lay Membership, with Mrs. Helen D. Halvorsen as Chairman.

✣

At the annual meeting of the Massachusetts Organization for Public Health Nursing in November the following officers were elected: *President,* Mrs. Harold Marvin, Chestnut Hill; *Secretary,* Mrs. F. L. Dellenbaugh, Brookline; *Treasurer,* Hilga Nelson, Newtonville.

✣

In a colored district in Rochester, N. Y., a group of expectant mothers have formed their own organization. They call it the Young Mothers' Club. These women are all registered in a hospital clinic which they attend regularly. The club meets once a week at one of the women's homes in rotating fashion. The hostess who is entertaining the club in her home serves light refreshments, always including milk or cocoa. The club has a schedule which they follow—fitting up the baby's toilet tray one week, cutting out baby clothes the next, sewing the next, etc.

✣

An ingenious way of bringing birth registrations home to a considerable portion of its population has been initiated by the Bureau of Public Health in New Mexico. When the automobile license plates were distributed by the state comptroller's office, each set of plates was accompanied by a slip, asking: "Attention, Fathers and Mothers! Your automobile is now legally registered. You can prove its age and ownership. Can you do the same in regard to your baby?"

APPOINTMENTS

Arkansas E.R.A. nursing activities are under the supervision of Mrs. Ruth Anderson, who succeeds Eupha Hixson. Miss Hixson returns to the State Health Department, from which she obtained a leave of absence to organize the E.R.A. nursing work.

Ada Newman, formerly with the Wisconsin Bureau of Public Health Nursing, has been appointed State Supervisor of E.R.A. Nurses for Nebraska, her home state.

Laura Johnson, Director of the Visiting Nursing Association of New Rochelle (N. Y.) has resigned and Mrs. Katherine Tucker Orbison is filling the position of Director of the Visiting Nursing Association at present.

Frances White, of the Saginaw (Mich.) Visiting Nurse Association, is acting director while Ann Hellner is studying at Teachers College.

The new officers of the Nebraska Examining Board are: *Chairman,* Gertrude Krausnick; *Secretary,* Ursula Penner.

" . . . I should like to tell you how thankful we are for the timely articles on **Medical Relationships** *and* **The Physician and the Visiting Nurse Association** *in the November magazine."*

A READER from Nebraska writes us the above and we are proud to print it, as who would not be!

Some one article to appear soon in PUBLIC HEALTH NURSING will be helpful to you in your daily "round." You will not want to miss *the* certain one. "Lapsing" a subscription may mean missing just the number you want most. By subscribing you can't miss.

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A Public Health Nurse in Greece • Summer Schools and Institutes (April) E.R.A. Projects (continued) • Mental Health of Convalescent Children